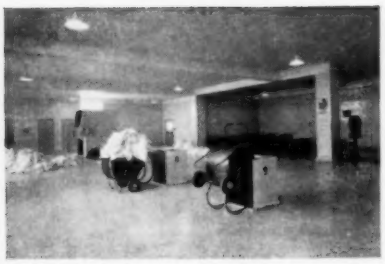
May, 1957

Canadian Hospital

- *Food and Drugs Act*
- *A good wage structure*
- *Employees' point of view*
- *Community mental hospital*
- *Hospital-Intern relations*
- *Accredited hospitals in Canada*

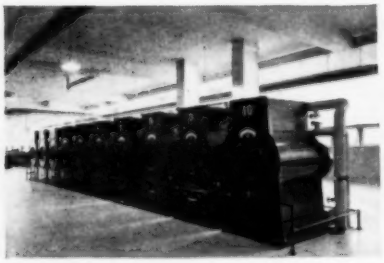
Canadian Hospital Association



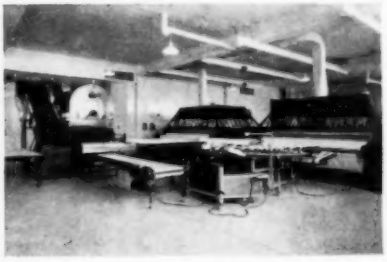
Work is sorted and classified in the soiled-linen room. It is then weighed and placed in easy-to-handle carts which are emptied into chutes leading to laundry.

Hoppers feed work from chutes directly into Cascade Unloading Washers. These large-capacity machines with Full-Automatic Controls are the ultimate in labor-saving equipment.

At the touch of a button hundreds of pounds of work are unloaded from washers into extractor containers. Overhead trolley and hoists convey containers to and from 60" Notrux Extractors.



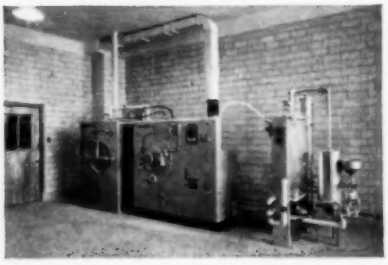
After extraction, work to be dried is conveyed to this battery of Zone-Air Tumblers. A total load capacity of 1100 lbs. indicates the tumblers' value in this high-production operation.



Completely mechanized flatwork finishing reduces operating personnel. Rotaire Conditioning Tumbler, Conveyors, Sager Spreader, Super-Sylon Ironers and Trumatic Folder speed-up work flow.

High-speed finishing of hospital garments and shirts rounds out variety of work laundry handles. Units include Super-Zarmo and Super-Zarmoette Presses and Tiltor Shirt Folder.

Three built-in Blanket and Curtain Dryers indicate the extent of planning and complete range of equipment supplied by the Canadian Laundry Machinery Company in this model installation.



An important part of the all-inclusive service performed by this modern department is the Model 30 Deluxe American-Martin Dry Cleaning Unit. Cleans up to 120 lbs. of work per hour.

Dry cleaning finishing is done with the latest model air-driven AceCo Presses. These presses assure fast, quality finishing with smooth, easy operation and maximum safety.

"Dream" Laundry for Canadian mental hospital

Modern premises, ample floor space and the world's finest laundry and dry cleaning equipment – make the laundry of St. Michel-Archange Hospital, Quebec, an ideal example of a fully equipped, efficient service department. The Canadian Laundry Machinery Company's planning help and complete line of equipment played an important role in creating this "dream" laundry. For complete information on how to streamline your laundry operation, write today.

Canadian

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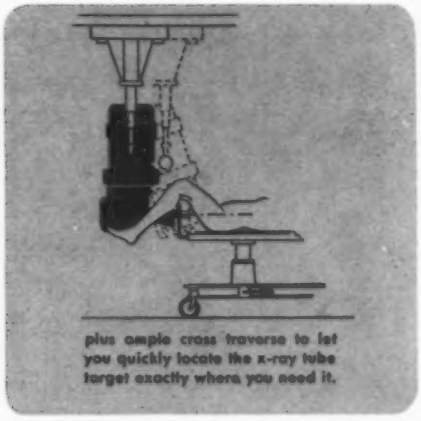
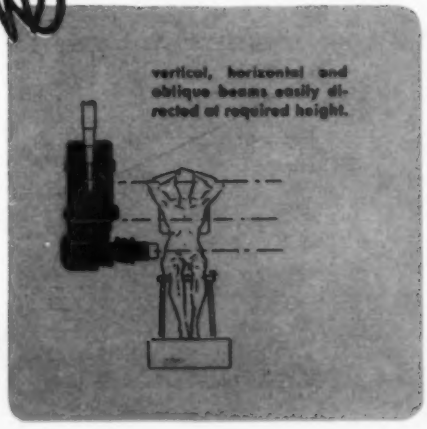
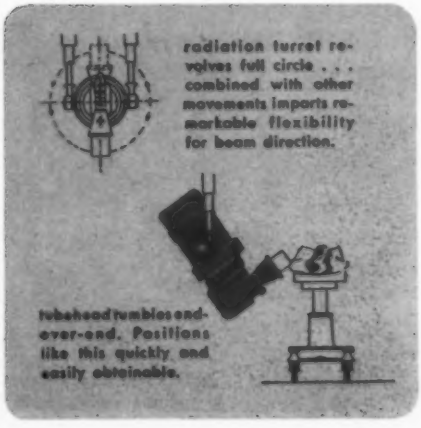
NEW for therapy

clears the floor

New Ceiling Mount for the Picker VANGUARD x-ray Therapy Unit leaves the floor completely free for maneuvering the treatment cart. Same lightweight, compact, free-swivelling (yet firm-locking) Vanguard tubehead that makes patient setup so quick and easy. Same automatic technic selection through Vanguard's unique Monitor Control. Easily mounted to conventional 9-foot ceiling . . . or higher (10′ 6″) with adaptor extensions.







ceiling-mounted
VANGUARD
x-ray therapy unit

PICKER X-RAY ENGINEERING LIMITED

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Contents

Vol. 34 May, 1957 No. 5

American-MacEachern

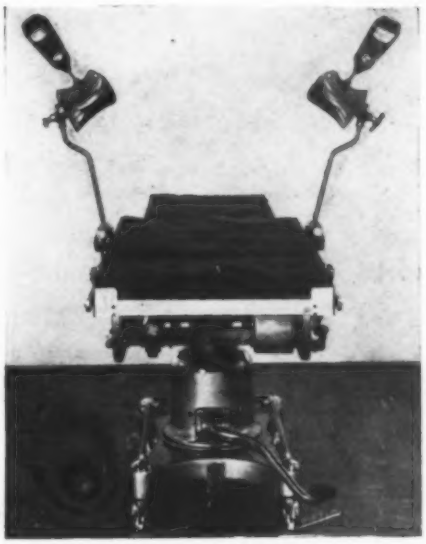
22" Operative Delivery Table.....

FOR ABDOMINAL OR PERINEAL ROUTE DELIVERY

• The new 22" **500N** table assures both the patient and the Obstetrician the fullest advantages of modern obstetrical practice under *all* conditions.

The growing practice of performing cesarian sections in the O.B. room . . . without moving or disturbing the patient . . . is made easy by the 22" surgery width of the **500N.** Yet the table will accommodate even the largest patient during normal delivery and the universally adjustable knee and foot rests accommodate all patients from the tallest to the shortest.

Write for bulletin C171



The "clean" lines of the 500N table provide maximum comfort and freedom for the surgeon . . . with toe space, folding handles, etc.

If non-elective cesarian section is indicated, patient is quickly and easily positioned for surgery simply by lowering extremities and raising the foot section. The anesthetist need not change position of head of patient.

15" height adjustment and every known obstetrical posture from high lithotomy to Walcher position provides convenient approach to the perineal field.

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Notes About People

Federal Appointments

Sylvia Gelber has been appointed as administrative officer in the Department of National Health and Welfare's Health Insurance Administration, a new administrative position set up in connection with the projected hospital care and diagnostic services program. Miss Gelber, a native of Toronto, is a graduate social worker. She joined the Research and Statistics Division of the Department of National Health and Welfare in 1950 and subsequently was appointed as a consultant in the department's Medical Rehabilitation and Disability Service.

Roger Goyette, B.A.,M.D.,D.P.H., has been appointed as assistant to the Principal Medical Officer, Health Insurance Administration, Department of National Health and Welfare. This senior position has been established in connection with the projected hospital care and diagnostic services programs. Dr. Goyette has been serving since 1953 as a Medical Officer in the Epidemiology Division.

Editor of New Journal

Dean Conley, executive director of the American College of Hospital Administrators, has announced the appointment of Lynn C. Wimmer as managing editor of the College's new quarterly journal, *Hospital Administration.*

Mr. Wimmer formerly served as assistant director of public relations for the American Hospital Association. He is a graduate of the Medill School of Journalism of Northwestern University, Chicago, Ill.

Hospital Board Presidents

Among those elected chairmen of their hospital boards are: Angus J. MacDonald, Glace Bay General Hospital, Glace Bay, J. H. M. Jones (chairman), H. K. Joyce (president) of Queens General Hospital Association, Inc., Liverpool, and Raymond MacPhee, New Waterford General Hospital, New Waterford, N.S.; R. C. Paul, Brockville General Hospital, Brockville, H. Cryderman, Bowmanville Memorial Hospital, Bowmanville, Jack Nickalls, Huntsville Memorial Hospital, Huntsville, T. McLellan, Kenora General Hospital, Kenora, Harold Solomon, Meaford General Hospital, Meaford, and H. M. Hicks, Prince Edward County Hospital, Picton, Ont.; Mrs. W. J. Hunter, Winnipeg Children's Hospital, Winnipeg, Man.; Mr. Fairweather, Kerrobert Union Municipal Hospital, Kerrobert, and J. R. Noyes, Lloydminster Municipal Hospital, Lloydminster, Sask.; Rev. F. A. Schole, Good Samaritan Hospital, Edmonton, Alta.; and Robert Buchner, Yellowknife District Hospital, Inc., Yellowknife, N.W.T.

Many Honour Administrator

Some 500 citizens of Chatham, Ont., paid homage to Priscilla Campbell, when she retired as administrator of the Public General Hospital, Chatham, Ont. At a testimonial banquet, Miss Campbell was presented with a scroll inscribed with the story of her life; a plaque was dedicated to her in the hospital's chapel; and she received a high fidelity phonograph. Presentation of scenes from her life was also part of the program.

Miss Campbell is a director of the Ontario Hospital Association, one of its past presidents and is a charter member of regional hospital council District 1. She is also a member of the American College of Hospital Administrators and a life member of the American Hospital Association. She was awarded a service medal by King George V.

William E. Bryans

Dr. W. E. Bryans, physician and surgeon at the Campbell Clinic, Lethbridge, Alta., and for many years superintendent of the Galt General Hospital in that city, died in March. A graduate in medicine from the University of Toronto in 1906, Dr. Bryans interned for two years at the Toronto Western Hospital, Toronto, Ont. He began his general practice in Carmangay, Alta., and after nine years joined Dr. Campbell in founding the Campbell Clinic.

H.O.M. Graduates Move

Alice J. Little, R.N., superintendent of Niagara Hospital, Niagara-on-the-Lake, Ont., since 1945, is now director of nursing at Ajax-Pickering General Hospital. Miss Little took over this new position in April. She is a 1954 graduate of the Hospital Organization and Management Course conducted by the Canadian Hospital Association.

Sister Florence Mary, R.N., since 1952 superior and administrator at St. Joseph's Hospital in Kenora, Ont., and previously assistant administrator at St. Paul's Hospital, Vancouver, B.C., became superior and administrator of the latter hospital in March. She is a 1954 graduate of the C.H.A. Hospital Organization and Management Course.

Medical Staff Chairmen

Among recently elected chairmen of their hospital's medical staff are: Drs. R. P. Cromarty, Brandon General Hospital, Brandon, and L. R. Rabson, St. Boniface Hospital, St. Boniface, Man.; J. C. Lanthier, St. Mary's Hospital, Montreal, Maurice Chrétien, St. Thérèse Hospital, Shawinigan Falls, and R. H. Steverson, Joyce Memorial Hospital, Shawinigan Falls, P.Q.; F. G. Knoll, St. Joseph's Hospital, Saint John, N.B.

George Frederick Strong

Many Canadian and American associations lost a valued member with the death of G. F. Strong, M.D., LL.D., F.R.C.P. (London, Eng., and Canada) on February 26 of this year. Dr. Strong was a native of St. Paul and graduate of the University of Minnesota. In 1926 he joined the staff of the Vancouver General Hospital, Vancouver, B.C. He became a senior in medicine in 1936, director of the heart station in 1930, and acted as chief of the department of medicine from 1946 to 1951. He became a diplomate of the American Board of Internal Medicine in 1938. Since 1951 he had been Clinical Professor of Medicine at the University of British Columbia. President of the National Heart Foundation of Canada, Dr. Strong was also a former president of the Canadian Medical Association and of the American College of Physicians. Although he specialized in heart ailments, Dr. Strong led the movement for the establishment of a central diagnostic and radiotherapy clinic for cancer which resulted in the forma-

(continued on page 22)

Until recently, very few in the profession questioned the adequacy of plaster of Paris bandages. It was felt that these bandages were satisfactory in most respects.

Now, Canadian orthopaedists have completed a 3½-year evaluation of this important subject, with rewarding results.†

Working in prominent teaching hospitals, these leading doctors made hundreds of casts using bandages of varying quality. When their reports were finally correlated, two things of major importance became evident:

First, the incidence of cast failures and breakdowns was considerably higher than had been suspected. This brought out the need for greater cast strength, particularly in the early stages of drying.

In addition, the doctors had, for the first time, set up standards for a superior, *and until now, non-existent* bandage.

With this information at hand VELROC was developed — the result of an entirely new formula and a new process.

Velroc*

PLASTER OF PARIS
ORTHOPAEDIC BANDAGES

*Trade Mark

†For a detailed report of this investigation write Director of:

ORTHOPAEDIC DIVISION

Johnson & Johnson

LIMITED MONTREAL

Notes About People

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tion of the British Columbia Cancer Foundation. He also was instrumental in the founding of the first Canadian rehabilitation centre for paraplegics and other handicapped persons, built in Vancouver in 1947.

On Air Pollution

Dr. F. A. Evis has been appointed chief of the new division set up to fight the problem of air pollution for the Ontario Department of Health. Dr. Evis was secretary of a legislative committee on air pollution which has made various recommendations to be implemented by this division.

Superintendent from Newfoundland

Major Fronie Stickland, formerly a director of nurses at Grace Maternity Hospital, Halifax, N.S., has been appointed superintendent of the Salvation Army's Evangeline Home and Hospital in Saint John, N.B. Born in Newfoundland, Major Stickland entered Grace Hospital, St. John's, Nfld., for training, and was the first graduate of that institution to become director of nurses there, following a post-graduate course at Toronto University's School of Nursing.

Assumes New Position

Gordon L. Pickering, since 1949 comptroller of St. Boniface Hospital, Winnipeg, Man., has been promoted to the position of business administrator of that institution. He is a director of the Manitoba Hospital Service Association (Blue Cross) and of the Canadian Hospital Association, and is a member of the Manitoba Hospital Rate Board.

• Jean Anderson, R.N., formerly of Montreal General Hospital, Montreal, P.Q., has become director of nurses at Victoria Public Hospital, Fredericton, N.B.

• Susan Porritt has retired from her position as superintendent of nurses at the Royal Columbian Hospital, New Westminster, B.C.

• C. Louise Bartsch, a former hospital superintendent, recently took over the post of nursing director at the Moose Jaw Union Hospital in Saskatchewan.

• George Ruley has been appointed the first laboratory x-ray technician at the Nicola Valley General Hospital, Merritt, B.C.

• Mrs. Viola Symons has been appointed matron, and J. E. Peterson, secretary, for a new long-term hospital being constructed in Claresholm, Alta.

• At the Alexandra Marine and General Hospital, Goderich, Ont., since March, 1952, Hilda Smith resigned in January as hospital superintendent.

• M. R. St. Louis, formerly accountant at the Hôtel-Dieu-de-St. Hyacinthe, St. Hyacinthe, P.Q., is now at Hôpital St. Vincent-de-Paul, Sherbrooke, P.Q.

• Alan Franklin Sykes, formerly in the medical records department at the Hospital for Sick Children in Toronto, Ont., since his arrival in Canada from Sheffield, Eng., last July, has taken up his new duties

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as administrator at the Windermere District Hospital, Invermere, B.C.

• Mrs. Margaret L. Colburn is the newly-appointed superintendent of the Lillian Fraser Memorial Hospital, Tatamagouche, N.S. She was formerly superintendent of nurses, and was succeeded in this post by Mrs. Ethel Campbell, a graduate of the Winnipeg General Hospital, Winnipeg, Man.

• Dr. R. Clarence Young, has left the staff of the Nova Scotia Sanatorium, Kentville, N.S., and is now medical superintendent of Point Edward Hospital, near Sydney, N.S.

• Mrs. Jean Scott, a staff member of Arnprior and District Memorial Hospital since 1952, has succeeded Edna Wolff as superintendent of nurses at that hospital.

• Canada's delegation to the tenth World Health Assembly, meeting in Geneva as of May 7, is headed by Dr. P. E. Moore, director of the Department of National Health and Welfare's Directorate of Indian Health Services.

• Dr. Geraldine Maloney will replace Dr. Marion Hilliard as chief of obstetrics and gynaecology at the Women's College Hospital in Toronto, Ont., when Dr. Hilliard retires from that post in May.

• Dr. M. Siminovitch has been named urologist-in-charge at St. Mary's Memorial Hospital, Montreal, P.Q., succeeding Dr. M. I. Seng who will continue to serve as consultant.

• Robert G. Aman has begun his duties in Winnipeg as controller and assistant business manager of the Winnipeg General Hospital, Winnipeg, Man.

• Mrs. Ethel MacLean has been appointed directress of nurses at New Waterford General Hospital, New Waterford, N.S.

Tolerance is the bigness that enables us to let people be happy in their own way instead of our way.—*Albert J. Robinson.*

Local Pathological Service

A new service in hospital care was put into operation last month as a result of several months of study and planning by a committee in the lower mainland of British Columbia. It is a pathological service offered through the co-operation of the Royal Columbian Hospital at New Westminster. It will involve a daily pickup of tissue from patients in hospitals on both sides of the river, which will be taken to the Royal Columbian for testing and returned the same day with a complete report as to malignancy. If the test shows a degree of malignancy the sooner the treatments are carried out the better for the patient. Provincial and Federal health authorities are watching this locally sponsored service with a view to recommending its adoption in other parts if it proves successful.

Public life is a situation of power and energy; he trespasses against his duty who sleeps upon his watch, as well as he that goes over to the enemy.—*Edmund Burke.*

W. Douglas Piercey, M.D., Editor

The Canadian Hospital

Obiter Dicta

Last Call for Saskatoon

BY the time the May issue of *Canadian Hospital* reaches your desk we expect you will have already packed your bag and finalized your arrangements to attend the Western Canada Institute for Hospital Administrators and Trustees and the 14th Biennial Meeting of the Canadian Hospital Association—both of which are being held in Saskatoon during the last week in May. This will be a unique opportunity for many hospital people to get together and exchange views. The primary purpose of the meeting of the Canadian Hospital Association is to conduct its business affairs. This will be in the hands of the accredited delegates appointed by the various hospital associations and Catholic conferences but it will give all those attending the institute an opportunity to learn more about the operation of their national association at first hand. While many items on the agenda of the Canadian Hospital Association are classified as business, many subjects on which hospital people should be well informed are to be considered. Among these are an all-Canadian program of hospital accreditation, the national hospital insurance program, financing of the national association, education programs of the association, and uniform accounting and statistics.

The Western Canada Institute for Administrators and Trustees is a well-known event and the majority of hospital administrators in the sponsoring provinces as well as a large number of trustees have, from time to time, attended these sessions and appreciate their value. Those attending from the East will be able to take in a first class educational program and the Saskatchewan Hospital Association, as host, is to be congratulated upon the energy and enthusiasm with which its officers have entered into the planning of this meeting.

In writing about hospital conventions in general, we have said repeatedly that the value obtained is not merely in the ideas engendered through formal papers and round table discussions. Invaluable though these are, we believe the informal contacts which delegates make with each other and with representatives of hospital supply houses, are a highly valuable part of the over-all convention. These enhance one's knowledge and broaden one's horizons just as much as formal sessions. This year the combined meetings will undoubtedly provide a particularly rewarding week. See you in Saskatoon.

Hospital Insurance and Diagnostic Services Act

BILL 320, "an Act to authorize contributions by Canada in respect of programs administered by the provinces, providing hospital insurance and laboratory and other services in aid of diagnosis", was passed by the House of Commons on April 10th, 1957. The Act comes into force on a day to be fixed by proclamation of the Governor in Council. Thus another important step has been taken in bringing national hospital insurance closer to reality.

Bill 320 should be read by all hospital administrators. Even in hospital circles there is misunderstanding concerning the intent of this legislation. The bill speaks for itself, and it is only by reading the complete text that one can understand its comprehensive nature.

The short title of the bill is "Hospital Insurance and Diagnostic Services Act". The interpretation, given under Section 2, outlines what the legislation will cover. Definitely excluded are: sanatoria, hospitals for the mentally ill, nursing homes, and institutions providing custodial care. The in-patient services covered are accommodation at *standard or public ward level*, including necessary nursing service, laboratory, radiological, and other diagnostic procedures, together with the necessary interpretation for the purposes of maintaining health, preventing disease, and assisting in the diagnosis and treatment of any injury, illness, or disability, and other services as listed under clause (f) of Section 2.

Section 5 sets out the terms of agreement between the Government of Canada and participating provinces. Section 6, clause 2, states that "no contributions shall be paid under this Act until at least six provinces, containing at least one-half of the population of Canada, have entered into an agreement, and the pro-

vincial law in relation to those provinces is in force." Before the bill passed the house, five provinces — British Columbia, Alberta, Saskatchewan, Ontario and Newfoundland—had indicated they were prepared to enter into an agreement with the federal government. Since then, Prince Edward Island has announced its intention of entering also and thus becomes the sixth province, the number required before the legislation could become operative. It is believed that one or two other provinces will make similar announcements in the not-too-distant future. It is reasonable to expect that payment to the provinces by the federal government under this legislation could begin in 1959 or possibly earlier.

Hospitals—be they lay, religious, municipal or provincial, general or special—are accustomed to dealing with their provincial governments. Hospital acts and regulations governing the operation of hospitals exist in all provinces. Where there are already provincial hospital insurance plans, hospitals are accustomed to having their budgets reviewed and to supplying detailed information and explanations, as required, regarding their financial position. Under Bill 320, hospitals will continue to deal with their respective provincial governments. However, as Bill 320 provides that the government of Canada will be expending large sums of money on hospital care, the agreement with the provinces provides, among other things, that a participating province shall undertake to make insured services available to all residents of the province upon uniform terms and conditions; and to make such arrangements as are necessary to ensure that adequate standards are maintained in hospitals, including the supervision, licensing and inspection thereof. It is to be expected that in the future an increasingly high standard of patient care, hospital administration, and accounting and statistics will be required.

All hospital administrators should have clearly in their minds the fundamental purpose of this legislation. While it is our belief that all levels of government appreciate the financial difficulties that boards of trustees encounter in operating hospitals, the primary intent of this legislation is not to assist hospitals financially. It is intended to spread the risk of possible hospitalization and the cost of associated diagnostic services over the whole population.

While many Canadians believe in the principle of voluntary prepayment for hospital care, as exemplified in the excellent Blue Cross plans, and while others have insured voluntarily with insurance companies on an indemnity basis, a large part of our population either would not or could not enrol under existing schemes. This is particularly true of rural populations.

In the late 30's, hospital authorities were prompted, on their own, to sponsor the Blue Cross movement, because of their everyday experience of seeing people harassed by hospital bills due to serious and prolonged illness. The patient then could not bear the double monetary loss of wages while ill and the cost of illness itself. The growth of the movement has justified fully the faith of the early planners. Blue Cross has been very successful, exceptionally so in those areas that were heavily industrialized, because the basic concept of enrolment in Blue Cross is a group payroll deduction plan. As a voluntary effort Blue Cross has rendered a valuable service to the people of Canada, and has pointed the way for a national hospital insurance program which will now cover all the population of participating provinces. In the long run, this should

prove as great a benefit to the whole population as Blue Cross has proved to those who have been its subscribers. Just as Blue Cross, as an indirect benefit, has assisted hospitals in meeting their financial obligations so should government-sponsored hospital insurance.

This does not mean that hospitals will have no financial worries in the future. Hospital people are one group who do not have to be told that it will still cost money to be sick. The difference under Bill 320, however, for the people of those provinces which participate with the federal government in this plan, is that the cost will be spread over the whole population —in that lies the virtue of Bill 320.

Air Stewardesses No Longer Need Be R. N.'s

TRANS-CANADA Air Lines have announced recently a change in their policy of employing only registered nurses as airline stewardesses. T.C.A. was the last North American airline to insist on having graduate nurses as stewardesses. All of us can recall the many debates that have taken place at hospital and nursing meetings on this topic. When the shortage of nurses was even more acute than at present, hardly a hospital or nursing convention was held where a resolution was not passed relating to this subject.

We believe it was by no means the resolutions which changed the thinking of T.C.A.—rather it was the problem of turnover which is not peculiar to that organization. Apparently the average length of service of nurses with T.C.A. is eight months. Considering the time and expense involved in training these girls for their positions, that is not a very lengthy term of employment. It is not that the girls do not like their jobs. Indeed they obviously enjoy their work—but they prefer marriage. T.C.A. has thus come to find out (as directors of nursing have known for a long time) that the turnover of nurses these days is phenomenal—the chief loss being to the marriage market. With good times prevailing economically this is true not only of nurses—but undoubtedly their profession is no hindrance to marriage. T.C.A. has adopted their new policy in an attempt to increase the length of service of employees. Directors of nursing have been working on this same problem and we suspect that in many instances the switch from the three-year curriculum for student nurses to the two-year study course, followed by the one-year so-called internship, has been largely dictated by nursing service demands for an adequate and continuing flow of general duty nurses.

Those of us who travel frequently by air have appreciated greatly the services which the registered nurses have rendered as airline stewardesses. However, with careful selection of personnel in the future, even though they may not be graduate nurses, the company will undoubtedly be able to maintain its high standard of service in this respect.

H.O.M. Summer Session

THE city of Winnipeg, fourth largest in Canada and known as the Gateway to the West, will this year be the location for the 1957 summer session for some 145 students in the Canadian Hospital Association's extension course in hospital organization and management. The session will begin on June 3rd and continue through to June 27th. This is the first time the combined summer sessions for all students have been held in the west.

Having completed another strenuous winter of home study, involving the assimilation of material in 14 lessons, much reading, the submission of regular assignments, and having successfully passed their written examinations, it might be expected that at a summer session, students would have a relatively easy time. On the contrary, however, the schedule of lectures, seminars, and group discussions, is exceedingly heavy as any student who has attended previous sessions will confirm. In these days when the emphasis in all lines of endeavour is on adequate preparation for the job, we take our hats off to those students who, while carrying on with an executive position in a hospital, have voluntarily set aside so much time to improve their knowledge of hospital administration. As any member of the faculty will tell you, meeting with this group is a stimulating experience and we are looking forward to renewing acquaintance with second year students and meeting those in their first year.

One of the important by-products of this extension course, resulting from the attendance at two summer sessions, has been the development of friendships and contacts among administrative personnel in hospitals from coast to coast. Conventions now take on an added lustre for many of the graduates who find in them an opportunity to renew friendships and meet other students who have or are taking the course. These associations can be rewarding at the personal level and helpful through discussion (by correspondence or conversation) of mutual problems and experience. In a country the size of Canada, any shrinkage of the regional boundary lines is a worthwhile achievement.

Canadian Hospital Directory, 1957

THIS is the fifth consecutive year in which revised and enlarged editions of the directory have been published by the Canadian Hospital Association. The 1957 directory follows closely the format of 1956. One major change has been the addition of a section on hospital construction. To make room for this division, last year's section on hospital accreditation has not been repeated. All other sections of the 1956 edition have been retained and in some cases expanded.

The section on "Educational Programs for Personnel" includes reference, for the first time, to courses available in accounting and purchasing. Again, hospitals approved for the training of interns, under the revised program of the Canadian Medical Association, have been listed, with relevant data concerning them. The section on nursing has been expanded by the inclusion of information on university courses in nursing. For the first time, a series of maps have been included with the list of hospitals showing the location of towns and cities where there are hospitals.

The section on construction gives general information on the volume of hospital construction in Canada and this data is further amplified in tables. One table lists all hospital construction programs in Canada which were completed in 1956, those under way in 1957, or planned for 1958. It is also indicated whether the project is an entirely new hospital, a new building replacing a former, whether the construction involved an addition to an existing hospital, renovation or extension of services. The total number of beds under the project are listed and the net gain in beds is noted. The table also includes information on construction of new nurses' residences or additions to existing ones and the construction of schools of nurs-

ing. In the summary of Table No. 1, this information is totalled for the province and the dollar value of the projects is shown. The information published on hospital construction has been obtained from individual hospitals, themselves, for the most part. The response to a special questionnaire forwarded earlier in the year has been gratifying and in most cases we know the cost or estimated cost of each individual project. For many reasons, it has not been considered wise, in Table No. 1, to show this cost with the individual project. Cost figures, however, as given by the hospital are used in arriving at provincial and Canadian totals.

The production of the directory entails considerable work for the association. We at the association offices, however, consider that the directory renders a valuable service to hospitals, hospital associations and conferences, and to all who are interested in or work closely with hospitals. The production of the directory would not be possible without the splendid assistance which we received from hospital administrators and other hospital personnel, allied organizations, government officials, and many others. The continued support of advertisers has made publication of the directory feasible. The Canadian Hospital Association is grateful to all who have contributed to the 1957 edition of the Canadian Hospital Directory.

Visites au patient

ON a souvent discuté la question de la limitation du nombre de visiteurs à l'hôpital. Beaucoup de solutions sont offertes, mais il incombe finalement à chaque hôpital de préparer son propre horaire de visites et de règlements. Ces horaires seront différents selon l'hôpital, la grandeur, genre de service, hôpital rural ou urbain, emplacement, et d'autres détails. La préparation d'un horaire de visites et de règlements est souvent plus facile que son application.

Dans beaucoup de cas, le patient profiterait d'une diminution de visites. La plupart des hôpitaux limitent le nombre de visiteurs qu'un patient peut voir à la fois, et quelques-uns ont établi des systèmes compliqués d'application des règlements de visites. Dans d'autres hôpitaux on a constaté qu'une prolongation des heures de visites aide à éviter qu'une foule de visiteurs envahisse les corridors à la fois, et qu'on peut aussi réduire ainsi le nombre total de visiteurs par jour. Il semble que les visiteurs ne profitent pas toujours du privilège de fréquentes visites.

Il ne faut pas oublier qu'il y a diverses catégories de visiteurs. Il y a l'ami indifférent qui vient par curiosité visiter le malade à l'hôpital—quoiqu'il n'aie pas vu le patient chez lui depuis des années. Il y a les parents éloignés qui viennent quelquefois circuler autour du lit ou s'asseoir sur le lit et qui nuisent à la routine des soins et de l'administration en fatigant le patient dont la période de convalescence est prolongée. Tout le monde connaît le visiteur qui veut égayer le patient et qui donne, par contre, une longue dissertation sur sa propre opération et toutes les complications survenues — un cas vraiment extraordinaire! A son départ, le malade subit une rechute.

On a beaucoup parlé de l'hôpital comme centre de santé pour la communauté. Au Canada aujourd'hui la plupart des gens font leur entrée dans le monde dans un hôpital, et le quitte dans un lit d'hôpital. La naissance et la mort arrivent fréquemment dans un hôpital. Ce ne sont pas, néanmoins, des événements ordinaires pour la famille en question. Dans les deux cas, ce sont des occasions où la famille immédiate doit recevoir une attention spéciale. L'arrivée d'un nouveau-né est une heureuse occasion, où le mari et la belle-mère méritent des privilèges spéciaux quant aux visites. Un hôpital peut beaucoup aider ses relations avec le public par des marques de faveur envers ces deux personnes. On ne doit pas oublier, non plus, la mère d'un enfant hospitalisé. Tout le personnel doit tenir compte spécialement d'un certain groupe de visiteurs. Ce sont les parents les plus proches, surtout ceux des patients sérieusement malades. Une famille n'a jamais plus besoin de considération qu'en temps de deuil. La mort vient, quelquefois, soudain et quand on ne l'attend pas; d'autres fois, elle résulte d'une période de maladie prolongée. Dans chaque cas, la femme, le mari, le père, ou la mère passe par une période difficile, et l'hôpital doit l'aider par tous les moyens possibles—avec sympathie, gentillesse, patience, et discrétion. Il est extrêmement triste de voir un membre de sa propre famille s'éloigner graduellement de jour en jour s'il n'y a aucun espoir de convalescence. L'hôpital joue à ce moment un rôle important. Quoiqu'il incombe au personnel de soutenir la vie tant qu'elle existe, les mesures thérapeutiques nécessaires pendant une maladie fatale doivent être administrées avec le moins d'embarras possible, pour ne pas distraire les membres de la famille qui sont présents. Il y a aussi, en même temps, d'autres choses à considérer que des mesures thérapeutiques. On peut être efficace et professionnel à la fois, sans perdre sa compréhension généreuse, et la sympathie envers ceux qui passent par une période de souffrance mentale. Ce sont ces faveurs qui ne sont pas demandés et que l'on prodigue à de telles occasions qui font de nos hôpitaux des institutions de guérison au lieu de simples machines mécaniques.

L'administrateur fait son rapport

PARMI les divers devoirs du surintendant d'un hôpital, un des plus importants est celui de tenir le conseil d'administration au courant de tous les aspects de l'activité de l'hôpital. La réunion régulière du conseil offre une occasion parfaite pour accomplir cette fonction, et toute mesure devrait être prise pour assurer qu'on réserve du temps suffisant à cette fin.

Le programme doit comprendre, comme travail courant, la question des "rapports de l'administrateur". Les rapports du surintendant peuvent être nombreux et variés. Ils devraient comprendre un rapport statistique, pour constater le nombre d'admissions et d'exéats du mois passé, le nombre d'heures cliniques, le nombre de lits occupés, de naissances et morts, et d'autres informations positives. Beaucoup d'individus jugent commode de rédiger un rapport en trois colonnes pour décrire (a) le mois courant, (b) l'année jusqu'à présent; et (c) une comparaison avec l'année précédente. La valeur d'un tel rapport est accrue si chaque membre du conseil reçoit une copie. Il est préférable de l'envoyer d'avance à chaque membre individuel.

Il va sans dire qu'il faut consacrer du temps, à la réunion du conseil, à l'examen des finances de l'hôpital. Beaucoup d'hôpitaux ont adopté un genre de rapport standardisé suivant lequel on note chaque mois les finances de l'hôpital en se référant au budget et aux chiffres de l'année précédente. Ce qui sera de première importance au conseil, ce sont les dettes actives, le compte en banque, et le nombre d'employés.

Il est entendu, quand il s'agit d'une lettre d'affaires,

(continued on page 60)

The supporting pillars of a

Good Wage Structure

T. M. Spencer,
Chairman,
Public Service Commission,
Regina, Sask.

STUDENTS and experts in the field of wage and salary administration say that the need for this field of study is well established. Some of them speak of the need in terms of employee morale and job satisfaction, on the one hand, and fair and equitable expenditures for services received, on the other. None of them, however, at least none whom I have consulted, make what to me is the obvious point—that inevitably every employer engages in wage administration. He may like it or loathe it, he may do it well or do it poorly, he may not realize that he does it at all; but if he employs people, just as sure as death and taxes, he is involved in wage administration. A certain company, I am told, decided some time ago that because it was too small an organization to cope with the powerful workers' union, it would pay the wages negotiated by a larger company. The result was that it nearly went broke. Another company that was plagued with too much absenteeism, high turnover, and excessive payroll expenses, blamed all sorts of external conditions for its plight. But when this company reviewed and improved its wage administration program, absenteeism, turnover, and payroll expenses shrank to normal proportions. The moral seems to be that since employers cannot escape wage administration and since ignoring it is likely to result in a variety of difficulties, in the interests of self preservation they should take wage administration seriously and make careful plans to deal with it as effectively as possible.

The objective of wage administration is of a twofold nature: (1) to determine a fair and equitable wage for every job, and (2) to provide for the handling of routine duties of the pay section including transactions like promotion and demotion. It is the first of these that I shall examine.

From an address given at an Institute for Hospital Administrative Personnel, 29th January, 1957.

It is impossible to evaluate jobs, it is impossible even to talk intelligently about them, unless you know what duties and responsibilities they involve. Consequently, in any plan for wage administration an essential foundation stone is the job description. In the preparation of job descriptions it is a good idea to start with an organizational chart even if one has to be made for the purpose. The description should include all essential duties but should leave out minor details. It should be reasonably short but should give an uninformed reader a clear understanding of the work that is done. There is no lack of literature about different procedures and refinements of the technique for gathering information and writing job descriptions and, as far as I am aware, no one method has achieved universal acceptance.

One good procedure includes the following steps: a. Have employees complete questionnaires about their jobs; b. Discuss his questionnaire with each employee; c. Discuss his questionnaire with each employee's supervisor; d. Write the description; e. Check the description with the employee and his supervisor to make sure it adequately describes the job.

Sometimes all of these steps are not used. It is essential, however, that the employee be interviewed and that both employee and his supervisor agree that the description gives a true picture of the job.

The descriptions provide information necessary for the job evaluation which can be done in any one of four ways: by ranking, classification, factor-comparison, or by point-evaluation.

The ranking method consists of considering the whole job and putting it in its proper place or rank in relation to the other jobs.

Classification consists of putting together in classes all jobs which resemble each other to the extent that the objectives of fairness and equity will be served if they receive the same rate of pay. Questionnaires are first divided into families according to the kind of work — clerical, inspectional, trades, et cetera. The questionnaires in each family are then divided into groups having similar difficulty and importance ranging from greatest to least. In this way classes such as Clerk I, Clerk II, Clerk III, and Clerk IV are established. This is much more difficult than it may sound. In the Public Service Commission it is considered that a technician cannot assume responsibility for classifying individual positions in an established system until he has a year of training and experience under supervision.

Factor-comparison and point-evaluation are variations of the same method. They both make use of factors such as skill, mental effort, physical effort, responsibility, and working conditions, which are supposed to be common denominators of all jobs. In factor-comparison, jobs are compared with respect to a whole factor, while in point-evaluation factors are broken down and point values assigned to each sub-factor, thus creating a point scale against which jobs are compared.

There are at least four different methods of factor-comparison and almost as many point-evaluation systems as there are agencies using them. The steps in one factor-comparison method are: (1) Select a number of key jobs; (2) Rank them five times, once for each factor; (3) Assign appropriate percentages to each job for each factor using 100 per cent for the highest ranking job in each factor; (4) Repeat step (2); (5) Repeat step (3); (6) Co-ordinate the results of steps (3) and (5); (7) Evaluate the remaining positions by comparing each one, factor by factor, with the key positions.

The steps in one point-evaluation method are: (1) Select a number of key positions; (2) Break down factors and assign points to each sub factor (*e.g.*, responsibility may appear as follows: Performance responsibility —160 points, Asset—133 points, Initiative—155 points); (3) Eval-

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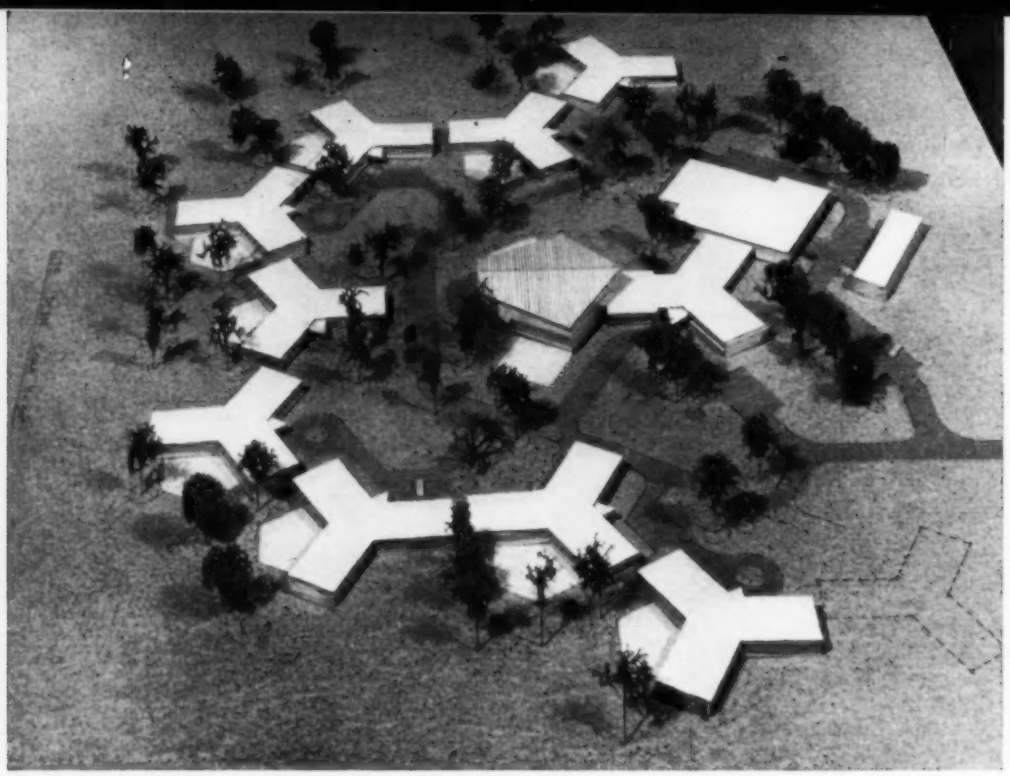

COMMUNITY MENTAL HOSPITAL

A proposed plan for co-ordinated psychiatric care in the Province of Saskatchewan providing small regional hospitals which would serve as the focus for the whole program of psychiatric care in the area.

MENTAL hospitals on this continent account for almost half of all hospital days care provided. It is true that the average length of stay is many times greater than is experienced in general hospitals, so the average experience on occupancy will differ. General hospitals which provide adequate accommodation for the population they serve find that their annual average occupancy is about 80 per cent of the beds provided. Mental hospitals might be expected, at the present rate of turnover of patients, to experience something between 95 and 100 per cent occupancy if sufficient standard accommodation were provided. The number of standard beds for mentally ill patients should therefore be something in the neighbourhood of 80 per cent of the number of beds provided in general hospitals, or a total number of beds about equal to the average general hospital utilization. On the basis of the 1956 experience in Saskatchewan we should have slightly over five beds per thousand population. It is interesting to note that this is the figure generally recommended by federal authorities and is also quoted in Section 622 (b) of the United States Public Health Services Act, Title VI, passed in August, 1946.

The need for more accommodation for mentally ill patients exists in pretty well all areas of Canada and the United States. Seeking the best solution for this problem in Saskatchewan, Dr. F. S. Lawson, director of the Psychiatric Services Branch, Department of Public Health, has applied the community mental hospital con-

cept as a desirable and economical way to provide adequately for the mentally ill. The firm of Izumi, Arnott and Sugiyama, architects and consulting engineers of Regina, have produced sketch plans of a proposed community hospital, with sufficient flexibility to be appropriate for any of our communities. The requirements of an adequate plan include:

1. Proper facilities for prevention of serious mental illness by early attention through a clinic service.

2. If hospitalization is required: (a) The hospital should not make the patient worse, for instance, hospitalization in large groups leads frequently to deterioration instead of improvement; (b) The hospital should contain facilities for adequate specific treatments; (c) The hospital should be situated where it is readily accessible to the patient and to the patient's relatives; (d) The hospital should have facilities for segregation of various types of patients; (e) The

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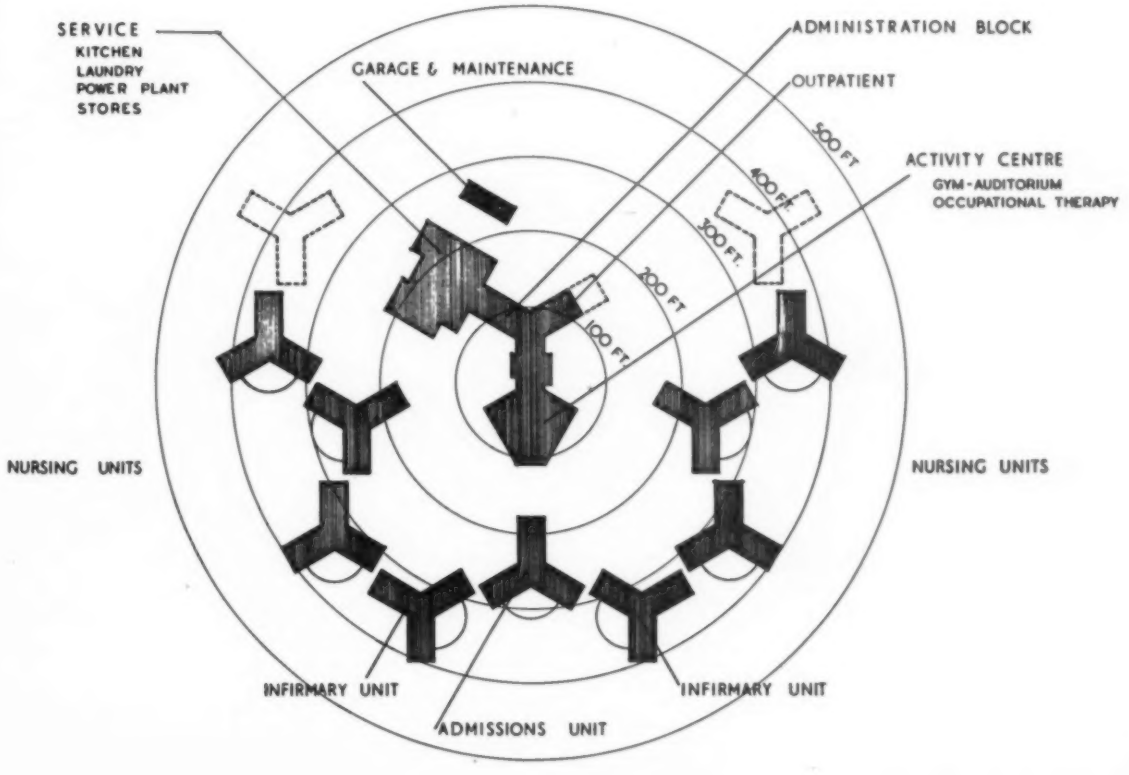
hospital should provide facilities to produce a milieu which will assist in the patient's recovery—embodying such items as decent human living conditions, privacy, occupational and recreational programs, good food preparation and service, social amenities, et cetera; (f) The hospital should have sufficient staff to provide personal attention to each patient; (g) The hospital should be small enough that the patient can feel he is a person and not an inanimate object.

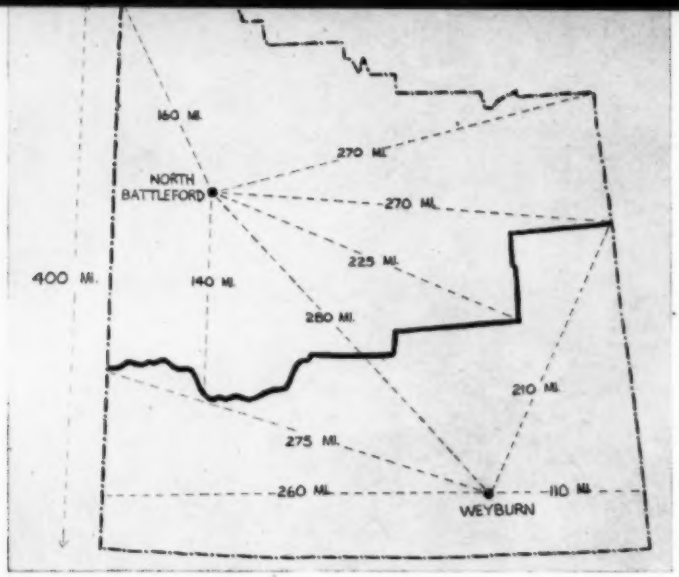
3. After hospitalization there should be adequate staff to prepare the family and the community for the patient's return to his home and a sufficient number of social workers and medical staff to give supervision of the patient at home, and to prevent readmission to hospital.

4. The capital and maintenance costs of a plan should not be exhorbitant as compared with other methods of providing the same care.

5. There should be a mental hospital within 80 miles of everyone to facilitate admission, rehabilitation, and visiting by patient's relatives. In areas where the population is distributed as in Saskatchewan there should be small hospitals of approximately 300 beds so that the radius of the area served will not be over 80 miles.

6. Five mental hospital beds should be provided for every 1,000 of population. Planning should be flexible enough to adapt to changes in population densities and advances in therapies. The rate of first admissions is increasing, apparently due not to an increase in mental illness but to a more widespread recognition of it. It will be most economical in the





Map showing distances from present mental hospitals to service area boundaries.

long run to accept this trend by providing enough easily accessible beds to encourage early treatment and so avoid an increasing load of long-stay patients.

7. Hospitals should be constructed in small units, each designed so that patients may be divided into smaller groups of 10 or less to allow for segregation of various types and also to allow for social relationships approximating those of the family rather than the military barracks. The type of therapeutic program which has been found most effective for a majority of mental hospital patients requires that the patients be dealt with and accommodated in groups not exceeding ten.

8. Each hospital should contain a large proportion of single rooms to allow for privacy, psychiatric interviews, and therapy.

9. Each hospital should contain a mental health clinic to take care of prevention and rehabilitation. Continuity of human contact would be retained by five psychiatrist and social worker teams who would take one day's duty each week in the out-patient service and the balance on in-patient. Each team would then retain contact with all patients seen on their clinic day. Through the out-patient, in-patient and rehabilitation services the patient would be seen by the same staff people. Organization and construction should be developed in such a way that expansion of the clinic may easily be accomplished. The flexibility of the unit should adjust to a balance between clinic and in-patient services at whatever point is determined necessary for the area. With active community services and certain advances in therapy which may alter the patient turnover, the ratio of clinic to hospital development may require a slight adjustment.

10. The minimum nursing staff/patient ratio should be approximately 1 to 2.3 because no nurse should have charge of more than 10 patients for group therapy and other therapeutic procedures. The ratio of 1 to 2.3 allows for one nurse to 10 patients during the two day-time shifts and 1 to 14.6 patients at night on the basis of a 40-hour week.

The Community Plan Recommended

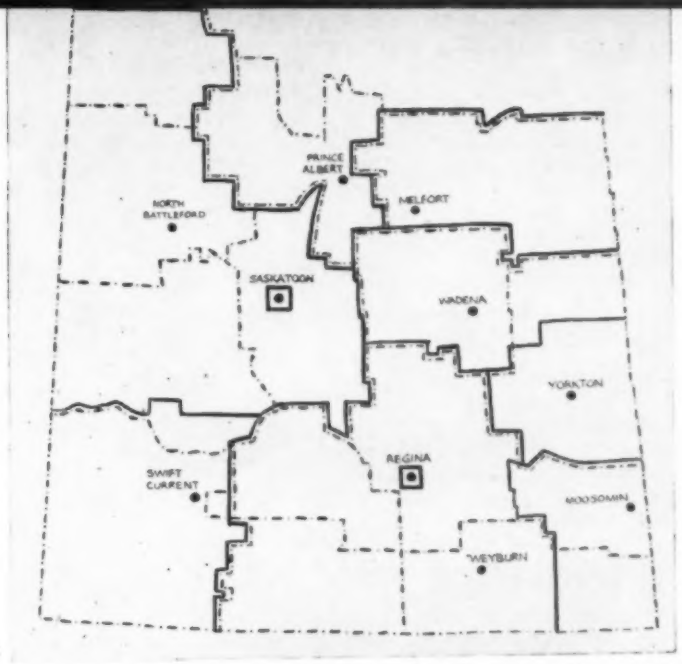
The southern half of Saskatchewan contains most of the 880,000 population. Apart from urban areas, the local government unit is the rural municipality, of which there are 316, and the local improvement districts, of which there are twelve. For the administration of health services in the province, these municipalities have been grouped into health regions. In this plan mental hospital community boundaries have been set out to coincide as nearly as possible with existing health region boundaries, to serve similar numbers of population and to include at least one well-equipped general hospital fairly centrally located in regard to access from all parts of the community. Duplication of costly facilities might well be avoided where services may be shared by the two hospitals. Services such as heating, laundry, clinical laboratory and x-rays are some that may be shared.

The two large mental hospitals which are presently in service would accommodate only the number of patients for whom standard accommodation could be offered. This would mean that each would serve about four health regions. A separate hospital unit at the Saskatchewan Hospital, Weyburn, would continue to care for all tuberculous mental patients. Eight new hospitals, each to serve as a focal point for psychiatric care in its region and each with an out-patient mental health clinic for prevention, therapy, and follow-up work, should be constructed in centres serving about equal numbers of people and where good general hospital facilities are already available.

Some Saskatchewan centres which offer the desirable location and facilities, and the recommended general hospitals are shown in Fig. 1.

Fig. 1—Characteristics of Hospitals

Hospital	Total Patients @ 1 in 200	Patient Units: Admission (20 beds)	Patient Units: Infirmary (34 beds)	Patient Units: Continued Treatment (30 beds)
Weyburn	1079 plus transients	—	—	—
North Battleford	1065 plus transients	—	—	—
Saskatoon	358	1	2	9
Regina	448	1	2	12
Swift Current	328	1	2	8
Yorkton	418	1	2	11
Prince Albert	328	1	2	8
Melfort	358	1	2	9
Wadena	418	1	2	11
Moosomin	268	1	2	6
TOTAL	5,068	8	16	74



Map showing tentative community mental hospital regions (solid lines) and existing health region boundaries (broken lines).

Construction

The sketch plans for the proposed hospitals have been developed by Izumi, Arnott and Sugiyama, architects and consulting engineers of Regina. Mr. K. Izumi states:

"Architects are charged with the responsibility of creating a part of the physical atmosphere in which we live but not too many of us have an opportunity to delve into the phychological, sociological and economic aspects of physical design. It is only when an architect is asked to design an institution such as a mental hospital that he suddenly realizes that what he is doing with colour, texture, space relationships and so on, has a most important impact on the behaviour of people.

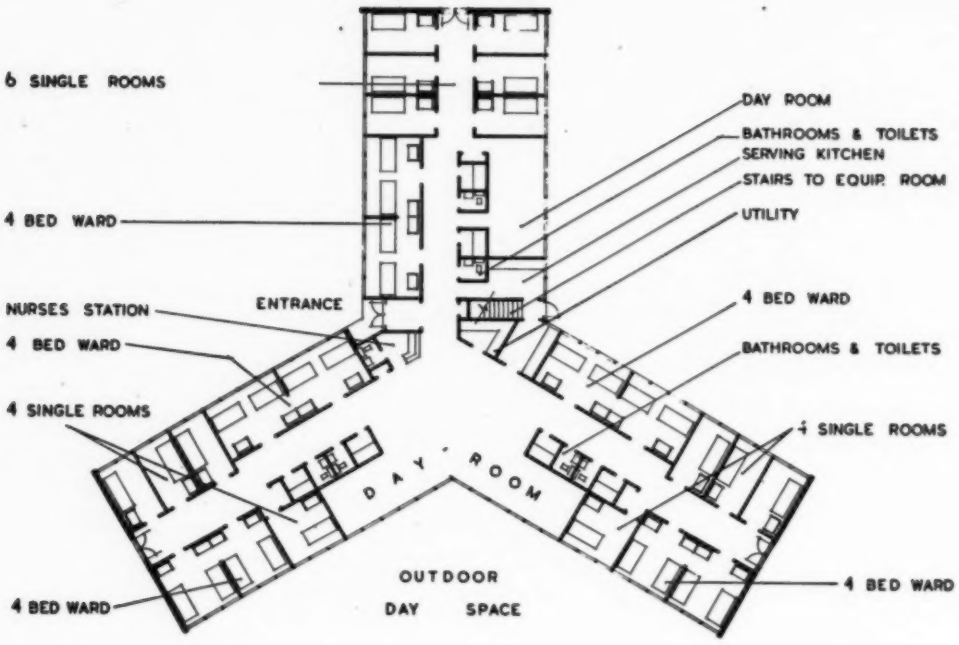
"In this case, we were faced with certain specific limitations: first, the plans had to be schematic as no actual site could be considered; and second, certain established space standards of the Canadian Government and those recommended by the American Psychiatric Association were to be followed. But the major difficulty in designing any psychiatric hospital is the fact that the people who give us the necessary information have only the past models to refer to and therefore the design usually is a doubtful improvement on what has been done before. Very seldom do we have an opportunity to go back to the fundamentals. In this particular instance, however, we did have an opportunity to go back to the fundamentals of what psychiatrists and others are trying to do for the mentally ill.

"Therefore I suggest that when psychiatrists criticize this or any future hospital design, they do so from the point of view of fundamentals, that is, from the basis of the needs which the buildings are intended to meet. It is relatively easy to compare this particular hospital with a larger hospital, or the relationship of the ward space to the dayroom space with what was done in Timbuktu. But I would like to hear these gentlemen criticize and suggest from their knowledge of the needs of the mentally ill patient, and how they are trying to meet these needs."

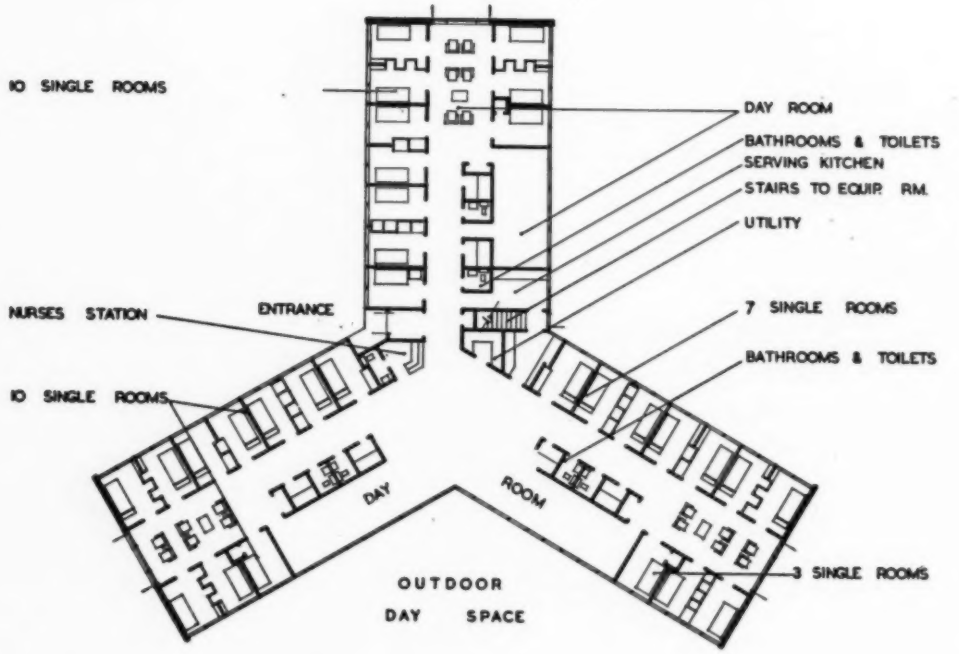
The basic design is the Y shaped building. Provision is made for as many single rooms as possible in the continued treatment buildings, with provision for conversion in the infirmary buildings to three-bed or four-bed rooms or alcoves. The single rooms may be used for individual interviewing or any type of treatment which requires privacy. The patient may, then, in his own building (a) be alone; (b) be in company with nine others in a day-room space; (c) be in company with 29 others in day room space or (d) outside his own building, he may associate with still larger numbers in the occupational and recreational facilities.

The central or core building of each hospital will have full basement and will house laundry, heating plant, stores, kitchen, staff dining room, business and administrative offices, staff locker rooms, out-patient clinics, chapel, canteen, and an occupational and recreational area. This building should be adequate to provide services for 448 patients.

A perspective study of a cottage group.



INFIRMARY UNIT



NURSING UNIT

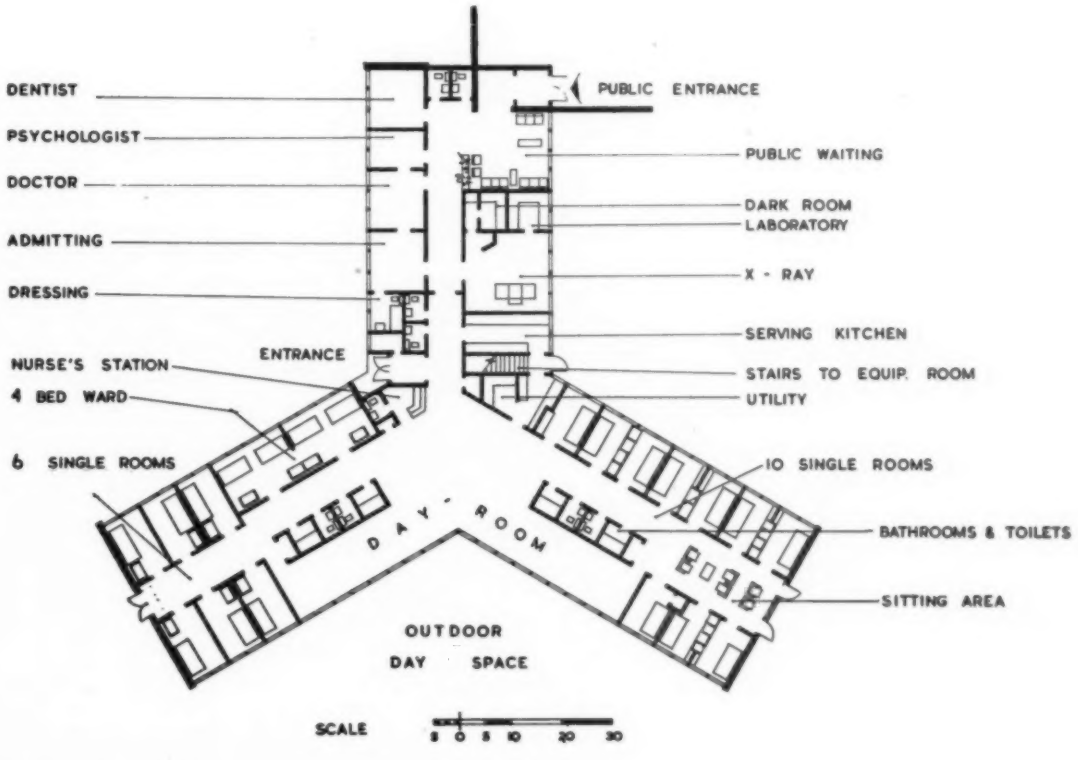
The size and external design of all the other buildings will be identical, with internal arrangements varied to provide the service for which the building will be used. These buildings will all be single-storey and Y-type without basements. They are to be heated from the central heating plant in the core building.

The centre patient building will be the admitting unit containing the necessary examining offices and accommodation for ten male and ten female patients. On either side of the admitting building is an infirmary—one for male and one for female patients. Each will accommodate ten acutely physically ill patients and 24 chronically physically ill patients. Continuing from each of these infirmary units will be a series of Y-type buildings for continued treatment, as many as may be required for the population of the region. Each of these nursing units for continued treatment will accommodate 30 patients. The plan is flexible in that partitions may be readily moved within the Y shaped buildings to adjust the ratio of space for continued treatment to infirmary care, et cetera, and the number of patient buildings may be increased according to need. If the number of younger types of psychotic patients decreases after buildings have been erected they may be readily adopted for senile psychotic patients, senile patients or chronically physically ill patients. If mental illness in both young and old should completely disappear, the buildings would be ideally suited as homes for the aged.

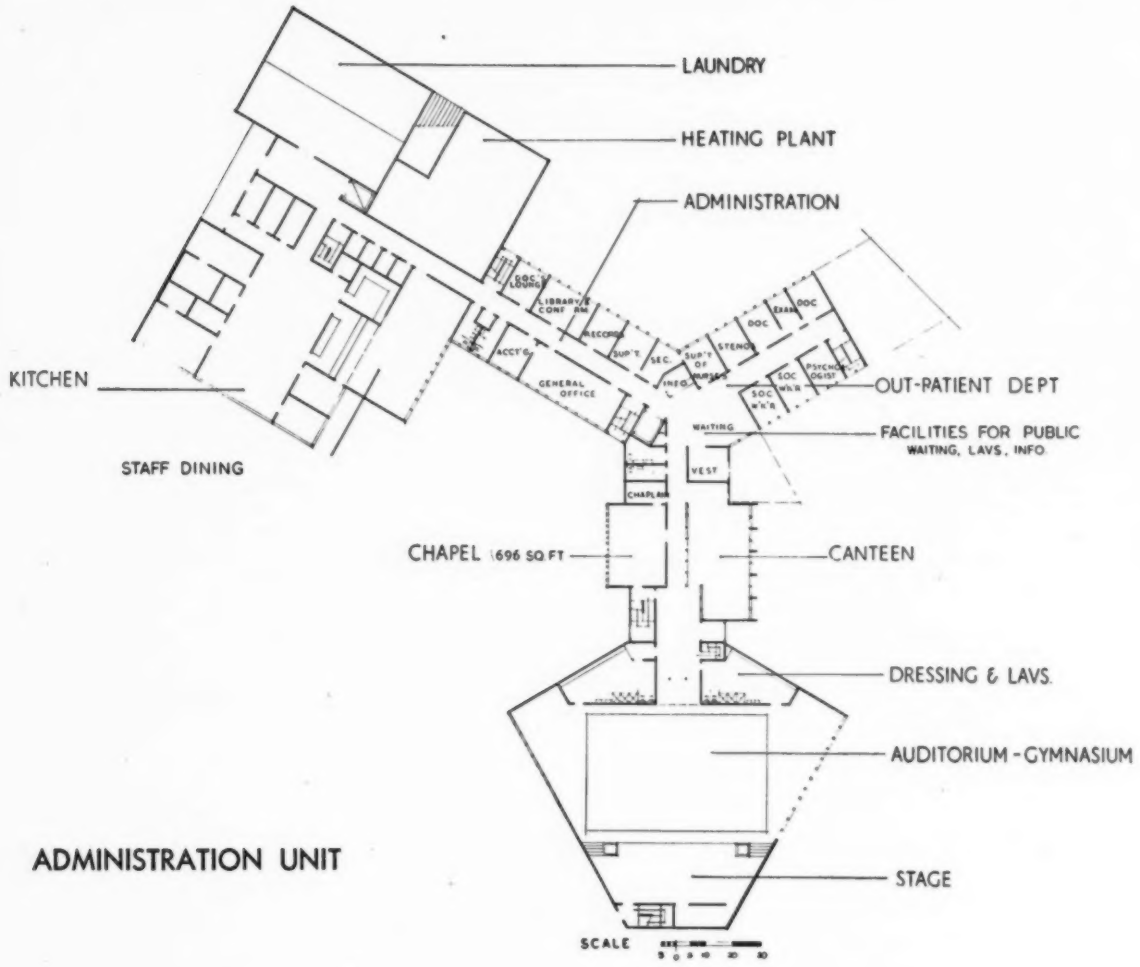
The Core Building

The administrative and activity centre of the hospital is in a core building which does not house any of the patients. While this building is basically the Y design of the patient buildings, it has large service areas added to two of the wings. From the main entrance and waiting room there is easy access to the out-patient department, to the administration and service wing and to the adjunctive therapies wing. The out-patient wing includes offices for two psychiatrists, two social workers, one psychologist and a stenographer, as well as a patient examining room. This wing may be readily extended as need for out-patient service increases. The chaplain's office, chapel and canteen are located in the wing which leads from the main entrance to the auditorium-gymnasium. In the basement of this wing are recreational therapy areas for bowling, billiards and ping pong, and rooms for music and occupational therapy. The third wing of the core building contains the administration offices and leads through to the service areas of the kitchen, staff dining room, heating plant and laundry. Central stores are located on the basement level in this wing.

The central patient building is designed as an admitting ward. One wing of this building has offices for doctors and dentists, psychologist, and social workers;



ADMISSIONS UNIT



ADMINISTRATION UNIT

an examining room, x-ray and clinical laboratory; for examination and admission of patients. Each of the other wings has accommodation for ten patients, most of whom have private rooms. A large day room opens onto an outdoor day space or patio which is so oriented that it serves only one building. Patients from either wing may, by closing folding doors, have a small day room for small group activities.

The food, which is prepared in the central kitchen, is delivered to the serving kitchen of each patient building in vacuum type containers from which it is served to the trays. The smaller day room spaces are intended to double as dining rooms for ten patients.

Next to the admitting building on either side is a 34-bed infirmary building. Patients in each wing of the building may gather in the small day room for that wing, or with the folding doors opened, a large day-room provides space for all ambulant patients who wish to assemble in a larger group.

The arrangement is similar in the continued treatment (nursing) buildings which accommodate 30 patients each. The number of patients which may be accommodated in the hospital is determined by the number of continued treatment buildings constructed. Five of these with the infirmary and admission buildings provide accommodation for 238 patients, the minimum size considered under this plan. By expanding to 12 buildings for continued treatment the hospital will accommodate 448 patients.

The buildings which house patients will not have basements. A crawl space around the perimeter of each will give access to the pipes which lead from the furnace room.

All other inter-building communication is above ground. The distances are not great, since all buildings of a 268 bed cottage hospital may be within a 400 foot radius of the administrative centre. The hospital should be on the lines of a small village, rather than an institution.

Where full hospitalization has served its maximum therapeutic purpose, the patient may be cared for on a day-hospital basis, on a night-hospital basis, in a boarding-out home or in his own home with out-patient attendance if needed and with constant availability of consultation with psychiatrists, psychologists, or social workers as indicated. The flexibility of this plan makes it easily adaptable to varying population densities and therapies required.

The employees' point of view

W. M. Black,*
Vancouver, B.C.

THE TASK of explaining the employees' point of view in employer-employee relationships is a very broad one, and so the subject has been broken up into five parts. I shall try to be as unbiased as possible in dealing with these questions.

(1) What should the relationship be between the administrator, the department heads and the employees?

(2) What should the hospital, generally, expect from the employees?

(3) What should the employees generally expect from the hospital?

(4) How does a trade union fit into the picture and what are its objects and responsibilities?

(5) What are the various factors that establish the bases for wages and conditions of hospital employees?

What should the relationship be between the administrator, the department heads and the employees? The administrator runs the hospital on the authority of the trustees and because of the complexity of hospital operations, he, of necessity, must delegate authority to his various department heads. They, in turn, become representatives of the hospital, junior administrators if you like, and the employees look to their department heads for leadership and guidance. That is the first contact with the administrative staff.

If the department heads are not properly instructed, or if there is no correlation in their thinking; and if a trade union contract or employees' contract is in operation and being interpreted in several different ways; or if employees do not clearly understand the line of authority—all this is reflected in the operation of the hospital, its productivity or its output of work. We are all interested in productivity. What boosts productivity, without interfering with patient care? A number of factors: good equipment to work with, efficient management, a healthy, resourceful, well-trained working force and, what is of the utmost importance, employee morale. And a low employee morale is brought about, generally speaking, through poor employer-employee relationships.

What should the hospital generally expect from employees? They should expect and receive a fair day's work, for a fair day's pay. They should receive the co-operation of the employees. Management should welcome opinions and suggestions from the empolyees as to the improvement of operations and should be prepared to co-operate and to accept from employees their considered opinions. It should be appreciated that the operation of a hospital is a co-operative venture. It is not a question of just management and labour. It is a question of good team work—all pulling together.

Employees Should Receive

What should employees generally expect from the hospital? They are entitled to proper working conditions, reasonable perquisites and fair wages—equal to what is paid in other public services. They should expect an atmosphere of co-operation and that management will consider their individual positions in the hospital. This could well be done through proper job classifications and job evaluations. There should be some adequate method of solving individual or group grievances. The best method of resolving this problem, is by labour - management committees, with equal representation from both sides. By pursuing these practices, staff difficulties that arise will be minimized and an improved environment will be created in which to work, thus giving a greater return to the hospital and to the patient and resulting in a happier employee.

Trade Union

How does a trade union fit into the picture and what are its objects and responsibilities? The trade union came into the hospital field because in the first instance hospitals generally failed to provide an adequate standard of living and proper working conditions for their employees. Hospital employees were treated as menial workers. The old saying applied: Yours not to reason why, yours but to do or die. Fortunately or unfortunately, whichever your point of view may be, hospital employees, like all other employees, are human—a factor which is so often overlooked. They desire the amenities of life enjoyed by the general working force in Canada and by all those in other public services, *i.e.* fair and reasonable wages, proper working conditions and perquisites which will adequately protect the hospital worker.

Trade unions have a contribution to make. I would be remiss if I failed to say they have been responsible for the majority of social reforms which we have on our statute books to-day. Unions are concerned, too, with the efficient operation and the organized approach to employees' problems. Why shouldn't employees be organized? All professions have developed an organized approach to their problems. Hospital authorities are organized through their associations. On the municipal level, the mayors and reeves are organized in the Union of B.C. Municipalities and Canada-wise in the Federation of Mayors and Reeves.

The influence of government in hospital administration today makes it desirable that the employees be organized to speak with one voice. The hospital worker must join hands with the rest of the organized working force, provincially and federally. There is also an area in which joint co-operation is vitally necessary between management and labour. What we have been confronted with here in British Columbia has not been collective bargaining in the true trade union sense, but collective begging. That not only applies to the hospital employees, but to the hospitals themselves in their dealings with the government. Hospitals are no longer charitable institutions in the way they were in days gone by. And the hospital workers, while making

(concluded on page 92)

** The author is business manager of the Hospital Employees' Union, Vancouver, B.C. This article is from a paper presented to the Eleventh Western Canada Institute for Hospital Administrators and Trustees, held in Vancouver, June, 1956.*

The Food and Drugs Act

F. S. Thatcher, Ph.D.,
Food and Drug Directorate,
Department of
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Ottawa

PERHAPS one of the more commendable aspects of government interest in health regulation is the positive concern for securing health and the prevention of disease rather than being concerned only with curing illness. It is within this progressive framework that the Food and Drugs Act of to-day functions. The officers of the Food and Drug Directorate have as an objective to make sure that all foods, drugs, and cosmetics offered for sale are safe and wholesome; and to take all possible steps to protect the consumer from fraud, adulteration, incorrect or misleading labelling and unethical advertising of all these commodities.

The Food and Drugs Act is thus essentially designed in the interest of the consumer. In this respect it is unique among Acts controlling foods. It is not primarily concerned with the expansion or direction of trade nor the development of new products.

It has contributed in no small part to the general high standard of foods and drugs that the Canadian consumer to-day has learned to expect. During the first few years of the existence of the Food and Drugs Act, which came into being 82 years ago, an average of 50 per cent of the food samples examined were adulterated or contravened the Act in some manner. To-day, the comparable figure is between 1 and 2 per cent. The Food and Drug Directorate does not wish, of course, to infer sole responsibility for this change. The fact that our food has reached such a comparatively high standard is clear evidence of the integrity of the large majority of producers and of the close collaboration that prevails between producers, manufacturers, and the officers of the Food and Drug Directorate. It is our positive policy to work towards securing collaboration, not only with the industries concerned but with all other agencies who have some interest under law in promoting the sale of foods, drugs, and cosmetics, that are safe and wholesome. Thus it is standard practice, before recommending any regulations under the Act to the Minister or Governor-General-in-Council, to forward a draft proposal to representative organizations of the trades concerned, and the various government departments who might also have cognate interests. Comment is invited, from which modifications are often made and a mutually more agreeable and sounder recommendation is secured.

From a paper presented to the Dietetics Section of the Ontario Hospital Association Convention held in Toronto, October, 1956.

Organization

While I shall confine the bulk of my remarks to aspects of "Food and Drugs" activity which are of more direct interest to those who have professional interest in foods, may I describe briefly something of our organization and its overall responsibility. There are three main services—administrative, laboratory, and inspection. Administration and the research aspects of laboratory enterprise are centred at Ottawa. The laboratory is one of a group of modern buildings forming the new National Health Centre of the Department of National Health and Welfare. Regional laboratories with branch offices in their immediate vicinities are strategically located across Canada. A large part of the control and enforcement activities emanate from the regional offices. The bulk of radio scripts advertising foods and drugs are examined at Ottawa.

A large proportion of the time of our laboratory service is occupied in research and investigation, for our Directorate realizes that within fields so technically complex as those of foods and drugs no control agency would suffice nor could it offer or maintain leadership without a well-equipped and well-staffed research laboratory. With the complexities of modern industry, no legislator or senior enforcement officer could carry out his responsibility without research men available for consultation. The Directorate calls for advice from senior research men who stay abreast of the advancing horizons in their respective fields not only by being responsible for appraisal of the world's scientific literature in those fields but also by personally taking part in and directing research projects having some specific relationship to the obligations of the Food and Drugs Act.

Laboratory Divisions

The work of the Directorate proceeds with such quiet effectiveness that most citizens know little either of the scope or of the complexities of our activities. Our laboratory service division is divided into no less than eleven sections each with its defined field of responsibility. Experienced scientists man the following distinct divisions: food chemistry; pharmacology and toxicology; vitamins and nutrition; cosmetics, food colours and alcoholic beverages; organic chemistry — which is largely concerned with the chemistry of narcotics and other addictive drugs; pharmaceutical chemistry; physiology and hormones; animal pathology; biophysics; biometrics; and my own section, microbiology. All are concerned to some extent in the development of analytical methods within their respective fields. Modern technology advances so rapidly that control agencies are faced with very severe problems in being able to keep abreast of methods for the detection and analysis of the new chemicals recommended for use both in food and as drugs. Our *food chemistry section*, for instance, working with the most modern of scientific instruments, faces a continuing challenge to develop adequate methods for the detection in foods of traces of the "army" of new insecticides, fungicides and other pesticides, some of which are highly toxic to man. The study necessary to establish what are safe levels of the new insecticides which may be tolerated in foods is a perplexing one indeed; and incessantly our progressive chemical manufacturers make available new pesticides, new emulsifiers, antioxidants, growth inhibitors and other compounds for which markets in the

food industry are desired. Meanwhile, the "inorganic" team within the food chemistry section must be continuously alert for the detection in foods of toxic elements such as lead, arsenic, and zinc. Spectrographic methods are generally used here. We must be concerned not only with the amount of toxic substance that may be present within a specific food, but this must be related to the estimated total intake of this substance from all foods. The safety of food additives or of trace contaminants must be judged not only by their immediate effects but also in relation to their possible propensities for accumulative or chronic injury.

The determination of the chronic toxicity of food additives is of particular interest to the *pharmacology section*, who also undertake study to determine the toxicity of drugs such as the cardiac drugs, pituitary hormones, the sympathomimetric amines, alkaloids et cetera, and undertake analyses to determine the potency of specific preparations of this kind. Of immediate interest is the determination of the interaction of drugs with barbiturates, for interaction may on occasion lead to dangerous modification of effect. For these studies, substantial colonies of experimental animals are maintained.

The work of this section, in turn, is quite closely related to that of the *physiology and hormones section* where, in addition to the chemical and biological determination of several hormones used as drugs, they are also interested in determining the safety and fate of adrenal and other hormone preparations, whether experimentally introduced into meat animals or used in treatment of arthritis. They would determine, too, estrogenic residues in meats, and are active in estimating any potentially harmful effects if foods containing added estrogens were to be consumed by humans. The *pharmaceutical chemists* are largely concerned with the development of methods of analyzing drugs other than the hormones and the vitamin preparations. The *animal pathology section*, in part is complementary to these and applies microscopic and histopathological tests to reveal the toxicity of drugs and food additives in tissues and specific organs of test animals.

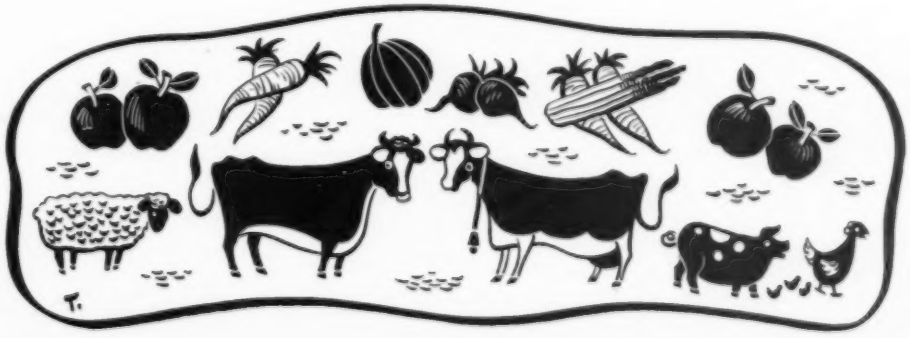
In our *vitamins and nutrition section* determinations of vitamins in foods and drugs are made primarily from the point of view of assuring that the commodities as marketed contain the potencies indicated on the labels or as otherwise indicated under law. To illustrate, they have recently satisfied themselves that the Vitamin A added to margarine maintains its stability for prolonged periods. They also are concerned in determining the availability of vitamins from specific foods and in specific commercial preparations. Interrelationships between specific vitamins, antibiotics, and amino-acids are also under study.

Their assay methods include chemical, biological, microbiological, as well as isotope-dilution procedures. This team studies also the effect of various food adjuncts on test animals. With regard to the use of bone-meal as an additive in flour, for instance, they have shown that when the iron content of the diet is low, bone-meal (if it contributes to an excess of calcium) may have an adverse effect on the regeneration of haemoglobin in experimental animals.

The *alcoholic beverages and food colours section*, apart from the control of the content and age of alcoholic beverages, has developed exacting methods for detection and recognition of specific food colours, renewed interest being stimulated by further experimental evidence of their toxicity and carcinogenetic propensities. The content of iron and copper in wines and the chemistry of aging liquors are among their current interests.

Our *biophysics section* is a newly organized one, and is being equipped for radioactive isotope studies. It will make its contribution towards keeping abreast of the times by undertaking studies of the effect of high energy radiation of food and drugs. This is important in order to be prepared for the outcome of the current experimental trend to use radiations from radioactive materials and other sources, such as the Van der Graff accelerator, in the sterilization of foods and drugs. In accordance with its usual policy, the Food and Drugs organization will need to be satisfied not only with the effectiveness of such processes, but must also be assured that degradation products within the foods do not offer a problem in toxicity or carcinogenicity. Further, we will need to be satisfied that such treatments do not significantly impair the nutritional qualities of the foods or the pharmacological action of the drugs.

The *microbiology section*, also, has a diversity of interests. All aspects of the microbiology of foods are of concern to it, whether from point of view of disease, toxicity, spoilage, or inclusion of extraneous matter. This section also completed a study of the sanitation of food - processing establishments, with one objective being to obtain a body of data which would support a recommendation for an amendment to the Food and Drugs Act; a modification of the Act, I might say, which since being promulgated in 1954 is very much a modernization and has led to major policy changes. Our research interest has been to learn something of the nature of the food-poisoning toxins and the factors conducive to their formation. We have worked out,



also, various methods for the estimation of specific kinds of contamination, of public health interest, as detectable on the surfaces of food-processing machinery or on factory surfaces. The definition of specific microbiological standards is another continuing interest.

The *biometrics section* advises on or undertakes statistical analysis of data from the various research and inspectoral services for the whole directorate. To withstand the challenge of the courts, as well as for scientific accuracy, sampling plans and experimental results must be exactingly determined and subject to the most critical of statistical examinations. The biometric section thus aids us in leaving very little to chance.

Control at Source

Some of you may pose a question as to this emphasis on research by an essentially "control" or "enforcement" agency. If the definition of research be allowed to include fact-finding investigations, I would advance the argument that research is a prerequisite to sound legislation in any field that involves diverse aspects of science and technology. For not only must legislation be based on the outcome of research, but many aspects of enforcement become dependent upon it also.

This point of view can be made clear by discussing some of my own experience with recent activities of the Food and Drug Directorate. The growing volume and intricacy of foods and of drugs on the Canadian market and considerations by the Food and Drug Directorate towards securing the most effective means of control, with the sparse manpower allotted to it, has led to a changing emphasis in control policy. Efficient performance and economics provide the rationale for a change from the "spot-check" system of examination of goods at the retail level, towards a policy of "control at the source".

But the old Food and Drugs Act lacked the empowering legislation for such a change. As I said before, a main function of the Directorate is to assure that all goods, drugs, cosmetics and medical devices offered for sale throughout Canada are safe and wholesome. With reference to foods this, of course, pertains not only to the content of standardized foods and the absence of adulterants but also to the presence of pathogenic organisms or those causing food-poisoning or to the possibility of the presence of otherwise dangerous germs. Similarly the Directorate would be concerned if foods were excessively contaminated with spoilage organisms or their products, or with rodent filth, flies and other insects, or other objectionable extraneous matter.

Survey

Our own experience is in accord with the text books, namely, that one of the most important sources of contamination of foods can be the food factory. Accordingly, this Directorate completed an extensive fact-finding survey of specific Canadian food industries. Our concern was to establish recordable facts on what was the status of sanitation as practised in flour mills, poultry processing establishments (including eviscerating and canning) and in the cheese industry and its associated milk production. This was the initial investigation. It should here be made clear that some factories were exemplary in most aspects of sanitation, ranging as this subject does from environmental cleanliness, adequate buildings and facilities, effective equipment, proper technological control, timing, refrigeration, pest control, cleansing and disinfection, proper packaging and storage, and last, but perhaps most important, hygienic practice by the workers, and informed sanitation-conscious management. I think most of us would agree, and certainly this is a positive attitude of this Directorate, that the most desirable form of quality-control is that originating from a sincere wish on the part of a well-informed producer or processor to market a safe wholesome product. We in the Food and Drug Directorate know that this prevails widely, but the situation encountered in our surveys showed that a minority of food manufacturers reveal either ignorance, carelessness, or gross abuse of elementary principles of hygiene.

Flour mills: After making some thousands of determinations of several different groups of micro-organisms and various categories of insect-matter, our microbiology section was able to establish a statistical correlation between the degree of insect infestation at specific sites within the mill and the content of micro-organisms in the flour. We were particularly interested in those micro-organisms that could cause spoilage when the flour was used in food manufacture, such as the thermophilic spores and the common mould spores.

Poultry industry: Our survey showed that the product was frequently excessively contaminated and that canned goods often would spoil upon incubation. The kinds and numbers of bacteria present in the cans revealed both gross contamination and under-processing, this being particularly true for establishments not under license from the Department of Agriculture and subject to inspection by the Health of Animals Branch. Laboratory results were corroborated by factory inspection. Buildings, equipment, facilities, and waste-disposal were often primitive and inadequate.

Cheese: In a proportion of the cheese the content of extraneous matter and of bacteria found was not in accord with modern concepts of satisfactory hygiene, in relation both to the production of milk and the manufacture of cheese.

The most worthwhile aspect to comment upon in connection with this survey is the opportunity it created to work towards improvement. Our data and supporting photographs were shared as pertinent with the industries concerned and their association leaders, and with the appropriate professional and government bodies. Fact was weighed in perspective with practicality and technological and economic problems. Consequent collaborative action between the manufacturers and educational and enforcement bodies, provincial and federal, has already resulted in substantial improvement on the part not only of manufacturers but in the elaboration of improved control measures. Substantial credit belongs to the majority of operators in the cheese industry for the recent advances they have made.

It is pertinent at this point to pose the question, what really is the public health significance of the classically unsatisfactory bacteriological picture in foods that we found in a proportion of food and food factories? The answer can-

not be free from equivocation, for proof of illness being caused by these Canadian foods is comparatively rare. Even from the aesthetic point of view, a microscope is required to determine a rat hair with any certainty, though the 150 retail specimens of cheese containing whole flies that we received over a three-month period two years ago were convincingly non-aesthetic.

The function of the Act, it seems to me, is essentially a prophylactic one, with emphasis on minimizing disease hazard, and in this light, if we consider our findings in perspective, we have to admit that health hazards do exist. We need no further reminder of the 1,500 cases of typhoid attributed to cheese in North America. Recent literature shows that the vector sources of undulant fever are still only partly recognized. The development of staphylococcal enterotoxin in foods remains ubiquitously the most common cause of food poisoning, while the development of antibiotic-resistance has given the staphylococci an entirely new and highly important significance. Proof of food poisoning from faecal streptococci is clearly established. Infection from paracolon bacteria is of positive record and botulism is fatal more often than not, while developments in virus study point to the rôle of foods as a vector, a rôle conditioned by unsanitary handling. Our survey studies demonstrated situations in which all of these hazards could be latent; and this quite apart from the fact that the Canadian consumer has the right to expect that reasonable precaution shall have been taken to exclude manure, flies and rat hairs from his foods; that his foods shall have been produced under conditions of sanitation shown to be economically obtainable and in accord with contemporary concepts of hygiene.

We now have some knowledge of what can be expected in degree of contamination under conditions of good commercial practice. It is important to note this last. No one is better aware than the Food and Drug Directorate that though bacteriological perfection may be an ideal, it may take on the naïveté of a fairy tale. Fairy tales have little place in industry.

It is against the recalcitrant minority who would be content to operate under conditions not conducive to public health that government control must primarily be directed. It was therefore a proper step, and a thoroughly logical one from the point of view of effective control and of economy, to seek enabling legislation to introduce the new policy of "control at the source". Our well-founded data indicated the need and provided the support for a clause in the new Food and Drugs Act, which states, "No person shall sell an article of food that was manufactured, prepared, preserved, packaged, or stored under unsanitary condition". And to make sure that the manufacturer also carries responsibility: "No person shall manufacture, prepare, preserve, package, or store for sale, any food under unsanitary conditions". To me it seems a credit to our Parliament that all parties in the House endorsed these new clauses which, as part of the New Food and Drugs Act, were promulgated in July, 1954.

Our activities in this field have already produced results that are a cause for some pride. Not only have our own inspectoral activities promoted substantial improvement by processors but several trade associations and leading manufacturers join with other agencies and with us in a truly dynamic progressive movement. One of our rôles is to sustain this concerted activity. Keeping all aspects of it in perspective will be no easy task.

The passing of an Act of this kind is not the end of the rôle of the scientist in legislation. Legis-

(continued on page 85)

Coming to Saskatoon?

Your hay foot up and your straw foot down!

Enthusiasm is running high in the western provinces and there is widespread conviction that the combined sessions of the Western Canada Institute for Hospital Administrators and Trustees and the biennial meeting of the Canadian Hospital Association (May 27 to June 1) will constitute one whale of a meeting. Quite aside from the pertinent value of business and educational features, our prairie friends hint at "pleasant surprises" during the latter part of the week. One evening is labelled "Go Western" and will include a typical western barbecue, held of course out of doors. Dr. A. L. Swanson, chairman of the program committee, wishes to suggest that those attending bring along sports clothes (checked shirts, jeans, peasant skirts, et cetera) and that all women attending bring along a pair of low-heeled shoes. In other words, be ready for hospitality in any shape or form. These westerners are no slouches! — *Edit.*

Accredited Hospitals in Canada

THE Joint Commission on Accreditation of Hospitals has recently issued a list of accredited hospitals as of December 31st, 1956. The names of the accredited Canadian general and specialty hospitals, other than hospitals for the mentally ill, are given below.

Our readers are reminded that the accreditation program is a voluntary service extended upon request to any hospital of 25 beds or over. If your hospital can meet the requirements of the Commission on Accreditation it should be listed. However, until a visit has been requested and a survey made the status of a hospital cannot be officially endorsed.

If the name of your hospital does not appear in this list, why not start the action that will assure its inclusion in subsequent lists of accredited Canadian hospitals? We hope to publish these annually.*

Alberta

Alberta Red Cross Crippled Children's Hospital	Calgary
Archer Memorial Hospital	Lamont
Baker Memorial Sanatorium	Calgary
Calgary General Hospital	Calgary
Charles Camsell Indian Hospital	Edmonton
Colonel Belcher Hospital	Calgary
Drumheller Municipal Hospital	Drumheller
Edmonton General Hospital	Edmonton
Holy Cross Hospital	Calgary
Lethbridge Municipal Hospital	Lethbridge
Mineral Springs Hospital	Banff
Misericordia Hospital	Edmonton
Provost Municipal Hospital	Provost
Red Deer Municipal Hospital	Red Deer
Royal Alexandra Hospital	Edmonton
St. Joseph's General Hospital	Vegreville
St. Mary's Hospital	Camrose
St. Michael's General Hospital	Lethbridge
University of Alberta Hospital	Edmonton

British Columbia

Burnaby General Hospital	Burnaby
Children's Hospital	Vancouver
Grace Hospital	Vancouver
Kelowna General Hospital	Kelowna
Mater Misericordiae Hospital	Rossland
Nanaimo General Hospital	Nanaimo
Nanaimo Indian Hospital	Nanaimo
North Vancouver General Hospital	North Vancouver
Pearson Tuberculosis Hospital	Vancouver
Powell River General Hospital	Powell River
Queen Alexandra Solarium (Paed. Orth.)	Cobble Hill
Royal Canadian Naval Hospital	Esquimalt
Royal Columbian Hospital	New Westminster
Royal Inland Hospital	Kamloops
Royal Jubilee Hospital	Victoria
St. Joseph's Hospital	Victoria
St. Paul's Hospital	Vancouver
St. Vincent's Hospital	Vancouver
Shaughnessy Hospital (D.V.A.)	Vancouver
Trail-Tadanac Hospital	Trail
Tranquille Sanatorium	Tranquille
Vancouver General Hospital	Vancouver
Vernon Jubilee Hospital	Vernon
Victoria Veterans' Hospital (D.V.A.)	Victoria
Willow Chest Centre (T.B.)	Vancouver

Manitoba

Brandon General Hospital	Brandon
Brandon Sanatorium	Brandon
Children's Hospital	Winnipeg
Clear Water Lake Sanatorium	The Pas
Deer Lodge Hospital (D.V.A.)	Winnipeg
Grace Hospital	Winnipeg
Manitoba Sanatorium	Ninette
Misericordia General Hospital	Winnipeg
St. Anthony's Hospital	The Pas
St. Boniface Hospital	Winnipeg
St. Boniface Sanatorium	Winnipeg
Shriners Hospital for Crippled Children	Winnipeg
Winnipeg General Hospital	Winnipeg
Winnipeg Municipal Hospitals	Winnipeg

New Brunswick

Carleton Memorial Hospital	Woodstock
Hôtel-Dieu de St. Joseph	Bathurst
Hôtel-Dieu de St. Joseph	Campbellton
Hôtel-Dieu de St. Joseph	Chatham
Hôtel-Dieu de St. Joseph	Edmundston
Hôtel-Dieu de St. Joseph	Tracadie
Kings County Memorial Hospital	Sussex
Lancaster Hospital (D.V.A.)	Saint John
Miramichi Hospital	Newcastle
Moncton Hospital	Moncton
Notre Dame de Lourdes Sanatorium	Bathurst
Restigouche & Bay Chaleur Soldiers' Memorial Hospital	Campbellton
Sackville Memorial Hospital	Sackville
Saint John General Hospital	Saint John
Saint John Tuberculosis Hospital	Saint John
St. Joseph's Hospital	Saint John
Sanatorium St. Joseph	St. Basile
Victoria Public Hospital	Fredericton

Newfoundland

Notre Dame Bay Memorial Hospital	Twillingate
St. Anthony Hospital (Grenfell Association)	St. Anthony
St. John's General Hospital	St. John's
St. John's Sanatorium	St. John's
West Coast Sanatorium	Corner Brook
Western Memorial Hospital	Corner Brook

Nova Scotia

Aberdeen Hospital	New Glasgow
Blanchard-Fraser Memorial Hospital	Kentville
Camp Hill Hospital (D.V.A.)	Halifax
Children's Hospital	Halifax
City of Sydney Hospital	Sydney
Colchester County Hospital	Truro
Eastern Kings Memorial Hospital	Wolfville
Fishermen's Memorial Hospital	Lunenburg
Glace Bay General Hospital	Glace Bay
Grace Maternity Hospital	Halifax
Halifax Infirmary	Halifax
Halifax Tuberculosis Hospital	Halifax
Harbour View Hospital	Sydney Mines

** This list, together with editorial comment, has been supplied by Dr. Karl Hollis, director, Canadian Commission on Hospital Accreditation.—Edit.*

Highland View Hospital	Amherst
Nova Scotia Sanatorium	Kentville
Payzant Memorial Hospital	Windsor
Point Edward Hospital (T.B.)	Sydney
Queens General Hospital	Liverpool
Roseway Hospital (T.B.)	Shelburne
Royal Canadian Naval Hospital	Halifax
Royal Canadian Naval Hospital	Cornwallis
St. Elizabeth Hospital	North Sydney
St. Joseph's Hospital	Glace Bay
St. Martha's Hospital	Antigonish
St. Mary's Hospital	Inverness
St. Rita Hospital	Sydney
Victoria General Hospital	Halifax

Ontario

Beck Memorial Sanatorium	London
Belleville General Hospital	Belleville
Brant Sanatorium	Brantford
Brantford General Hospital	Brantford
Cornwall General Hospital	Cornwall
Daughters of the Empire Hosp. for Conv. Children (T.B.)	Toronto
Deep River Hospital	Deep River
Douglas Memorial Hospital	Fort Erie
Essex County Sanatorium	Windsor
Fort William Sanatorium	Fort William
Freeport Sanatorium	Kitchener
General Hospital of Port Arthur	Port Arthur
General Hospital	Sault Ste. Marie
Grace Hospital	Windsor
Greater Niagara General Hospital	Niagara Falls
Guelph General Hospital	Guelph
Hamilton General Hospital	Hamilton
Hospital for Sick Children	Toronto
Hotel-Dieu Hospital	Cornwall
Hotel-Dieu Hospital	Kingston
Hotel-Dieu Hospital	St. Catharines
Hotel-Dieu of St. Joseph	Windsor
Humber Memorial Hospital	Weston
Kitchener-Waterloo Hospital	Kitchener
Kingston General Hospital	Kingston
Kirkland & District Hospital	Kirkland Lake
Leamington District Memorial Hospital	Leamington
McKellar General Hospital	Fort William
Metropolitan General Hospital	Windsor
Mountain Sanatorium, The	Hamilton
Muskoka Hospital for the Treatment of Tuberculosis	Gravenhurst
New Mount Sinai Hospital	Toronto
Niagara Peninsula Sanatorium	St. Catharines
Norfolk General Hospital	Simcoe
North Bay Civic Hospital	North Bay
Northwestern General Hospital	Toronto
Oshawa General Hospital	Oshawa
Ottawa Civic Hospital	Ottawa
Ottawa General Hospital	Ottawa
Owen Sound General & Marine Hospital	Owen Sound
Peel Memorial Hospital	Brampton
Penetanguishene General Hospital	Penetanguishene
Peterborough Civic Hospital	Peterborough
Plummer Memorial Public Hospital	Sault Ste. Marie
Port Colborne General Hospital	Port Colborne
Public General Hospital	Chatham
Ross Memorial Hospital	Lindsay
Royal Ottawa Sanatorium	Ottawa
Runnymede Hospital	Toronto
St. Catharines General Hospital	St. Catharines
St. John's Convalescent Hospital	Newtonbrook
St. Joseph's General Hospital	Brantford
St. Joseph's Hospital	Chatham
St. Joseph's Hospital	Guelph
St. Joseph's Hospital	Hamilton
St. Joseph's Hospital	London
St. Joseph's Hospital	North Bay
St. Joseph's Hospital	Peterborough
St. Joseph's Hospital	Port Arthur
St. Joseph's Hospital	Sarnia
St. Joseph's Hospital	Sudbury
St. Joseph's Hospital	Toronto
St. Lawrence Sanatorium	Cornwall
St. Louis-Marie de Montford Hospital	Ottawa
St. Mary's Hospital	Kitchener
St. Mary's Hospital	Timmins
St. Mary's of the Lake Hospital	Kingston
St. Mary's on the Lake Sanatorium	Haileybury
St. Michael's Hospital	Toronto
St. Peter's Infirmary	Hamilton
St. Thomas-Elgin General Hospital	St. Thomas
St. Vincent de Paul Hospital	Brockville
Sarnia General Hospital	Sarnia
South Waterloo Memorial Hospital	Galt
Stratford General Hospital	Stratford
Sudbury-Algoma Sanatorium	Sudbury
Sudbury General Hospital of the Immaculate Heart of Mary	Sudbury
Sunnybrook Hospital (D.V.A.)	Toronto
Toronto East General & Orthopaedic Hospital	Toronto
Toronto General Hospital	Toronto
Toronto Hospital for Tuberculosis	Weston
Toronto Western Hospital	Toronto
Victoria Hospital	London
Welland County General Hospital	Welland
West Lincoln Memorial Hospital	Grimsby
Westminster Hospital (D.V.A.)	London
Women's College Hospital	Toronto
Woodstock General Hospital	Woodstock

Prince Edward Island

Charlottetown Hospital	Charlottetown
Prince County Hospital	Summerside
Prince Edward Island Hospital	Charlottetown
Provincial Sanatorium	Charlottetown

Quebec

Alexandra Hospital	Montreal
Barrie Memorial Hospital	Ormstown
Bégin Sanatorium	Lac Etchemin
Cardiologie de Montréal, Institut de	Montreal
Catherine Booth Mother's Hospital	Montreal
Christ-Roi, Hôpital du	Nicolet
Comtois, Hôpital	Louiseville
Cooke, Hôpital-Sanatorium	Trois Rivières
Enfant-Jésus, Hôpital de l'	Quebec
Grace Dart Hospital	Montreal
Hôtel-Dieu d'Arthabaska	Arthabaska
Hôtel-Dieu de Hauterive	Hauterive
Hôtel-Dieu de Lévis	Lévis
Hôtel-Dieu de Montmagny	Montmagny
Hôtel-Dieu-de-Montréal	Montreal
Hôtel-Dieu Notre-Dame de Beauce	St-Georges-Ouest
Hôtel-Dieu de Québec	Quebec
Hôtel-Dieu de St-Jérôme	St-Jérôme
Hôtel-Dieu de Sherbrooke	Sherbrooke
Hôtel-Dieu de Sorel	Sorel
Hôtel-Dieu de St. Vallier	Chicoutimi
Hôtel-Dieu de Valleyfield	Valleyfield
Hôtel-Dieu du Christ-Roi	St. Joseph d'Alma
Jeffery Hale's Hospital	Quebec
Jewish General Hospital	Montreal
Jewish Hospital of Hope	Montreal
Joyce Memorial Hospital	Shawinigan Falls

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For Trustees Only:

Financial Problems

S. W. Martin,
Executive Secretary-Treasurer,
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Toronto, Ont.

THE administration of hospitals may not always have been seriously complicated by economics and finance, but it seems to the writer that this phase of every conscientious administrator's way of life has for a good many years been materially affected by financial problems.

We are all aware that general inflationary trends, so evident in our total economy for the past two decades, has demanded an increasing amount of the time of every hospital trustee and administrator; and careful evaluation of present day conditions plus any possible crystal gazing processes would seem to indicate this will be our lot for some time to come. That financial problems in hospital administration are no longer reserved exclusively for trustees and administrators of hospitals themselves is, I believe, becoming abundantly clear. We in this nation now live with the probability that the people, through their governments, intend to take a lively interest and exert a really centralized influence in the affairs of all our hospitals. Why? Primarily because of problems arising from the financial aspects of providing hospital care. That this stirring of the people is certainly not limited only to this country is evident from the remarks of the insurance commissioner of the State of Michigan, the Hon. Joseph A. Navarre, when he said—"Irrespective of the merits of hospital contentions, a powerful and vocal segment of Blue Cross subscribers contend the cost is 'too high' for the services they want. Much as we might deplore the fact, it is apparent that the measure of selfishness and greed inherent in human society is threatening the continued existence of a noble experiment. A prostitution of its worthy objectives is gnawing at the very vitals of the plans.

"Innocent blundering, thoughtless, and sometimes deliberate misapplication of legitimate purposes, disturb the delicate balance of the social and economic justice necessary to the preservation of the plans as a social mechanism. Surveys and investigations indicate that the predators of the systems through 'abuse, faulty utilization, over-utilization' and in devious ways are driving the cost of the services beyond the means of large segments of society. To the extent that the numbers of those served by the systems become limited, through a cost beyond their reach, to that extent do the systems fail of their objectives, as a mechanism providing hospital and medical care on a voluntary prepaid, non-profit basis . . ."

While, as the science of hospital administration has developed, it has been necessary to emphasize the responsibilities that governing boards and administrators should have for the quality and quantity of medical care and certain other phases relating to actual treatment of our patients, it is quite apparent that responsibility for efficient and economical management has, for a long time, been considered as a basic and fundamental obligation of the administrator. This being the case, the degree to which this obligation has been fulfilled has undoubtedly played a very important part in our professional life as hospital administrators. What then are some of the tools which we should be using to assist us in this task?

Basically, of course, we must see that the vehicles in our hospitals which carry the responsibility of collecting and paying out monies and accounting for them, as well as furnishing us with a statistical story of our continuing operations is sound, is efficient and above all capable of producing accurate financial and statistical assessments upon which sound policy can be established and proper explanations given to substantiate our changing financial requirements. Having satisfied ourselves that sufficient and proper personnel are maintaining these procedures, are we making the best use of these potentials? Are we carefully evaluating and giving adequate attention to the dynamic story of what is going on in our hospitals, and is the story which is told by the daily, weekly and monthly financial and statistical reports and statements doing so? Are we making sure that reports produced in a routine fashion are actually what are needed? Have some outlived their usefulness? Concise and specific direction as to the type of information required is an administrative function and should not be left entirely to the determination of the accountant, the librarian, or other personnel concerned.

Reading Financial Reports

Are we reading our financial reports intelligently? Several current financial problems can be followed in our "balance sheets". Are we properly evaluating our "net worth"? Is a larger percentage of our current assets being tied up in inventories than is feasible in a still changing market? Can we meet current debts with liquid assets? Are our accounts receivable increasing to a point where our cash accounts show overdrafts which can contribute to increased operating expenses? Despite a high level of employment and generally buoyant economies, as well as extensions of prepaid hospital care plans, many of our hospitals have experienced increasing collection problems. Careful attention to cautionary reports of higher levels of consumer borrowing and installment financing should be heeded by the administrator, because this is a sure sign-post that difficulties in collecting accounts for unexpected hospitalized illness may be expected. Just because people are earning money does not mean they have it to pay hospital bills for which no allowance has been made in their personal budgets. Growth of prepayment plans, while undoubtedly the salvation of hospital finances, requires the administrator to develop changing standards of evaluation for the

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From an address presented to an Educational Conference on Administrative Problems of the American College of Hospital Administrators held in Toronto, April 30 to May 4, 1956.

ever-present collection problem. While payment of a large portion of the total bill may be guaranteed, what effective steps have been taken to care for collection of remaining balances? Even more pertinent—are your accounts being billed promptly to the third party agency? If so, are you receiving prompt payment? If not, why not? Is part of your collection problem developing because of lack of proper relations and communications as between your business office and servicing and treatment departments? Are there too many charges arriving at the business office after the patient's discharge or after the account has been billed to the third party? Has your present method of charge advice to the business office outlived its usefulness and does it require modifications? This is one problem that can be affected by the size of the hospital but even so, with all personnel costs steadily increasing, every administrator should be searching for better techniques to provide speedy and simple methods of converting services required for the patients into proper advice to servicing departments and business office personnel. Every effort should be made to utilize multiple copy advice forms requiring a minimum of writing or rewriting to achieve the results desired.

Comparisons

Are our income and expense statements examined only for net result without proper attention to component parts? A wealth of knowledge can be gained for the future from these reports if they are properly analysed and interpreted. To aid in controlling finances, comparisons must be made with past periods, our own budgets and those of other similar institutions. Within each report and between reports, it is possible to analyse various sections to determine the effectiveness of management. Proper interpretation aids in judging past as well as future performance. When increase-decrease or trend comparisons are shown on statements, these should indicate to the administrator what corrective steps are required. Most of our hospitals now depend largely upon day-to-day operations and resulting income from charges for services rendered to keep their front doors open. This has placed growing emphasis upon an adequate schedule of rates for all services provided.

Multiple Charges

Many of us are facing difficult problems in relation to this very question of rates. In a sincere endeavour to keep our charges for rooms or wards at as low a figure as possible, every probable avenue of charging for so-called "extra" services seems to have been developing. I submit that in many instances this trend has caused us to overlook the very basic facts that some of our properly prepared cost figures have revealed. It has also led us further and further into a complex system of multiple charges which has added to our general administrative costs as well as making our accounts for services rendered almost incomprehensible from the standpoint of the average patient. From our own experience we have seen hospital accounts with extra charges for such items as small amounts of cleansing tissue, individual charges for asperin tablets and even a specific entry for "routine enema". Before instituting such charge systems, have we as administrators actually calculated how much it costs us, administratively, to process a charge of this nature? Undoubtedly in many cases the cost of paper and clerical work involved amounts to far more than the actual charge being made.

Changing treatment practices can be detected from a careful study of our financial statements. A very proper development in surgical and obstetrical services is the provision of recovery or first-stage rooms where concentrated nursing care can be provided when required. Looking for some method of increasing income, some of us consider it advisable to add extra charges for use of these facilities. Would it not be better to face up to the fact that such arrangements are as much for our convenience and planning as for the better care of the patient and allocate cost of such service to daily routine care or a continuation of the operating or delivery room procedure? Is not the patient perfectly justified in questioning why he or she should pay for a bed in a room, a table in the operating suite, and a bed in recovery quarters, all at the same time? Assuredly we must balance our budgets, but are we not in such moves only aggravating the practice of selling hospital care on a bits-and-pieces basis rather than as a whole product? Are not these almost unlimited "extra" charges one of the main financial problems, public-relations-wise, which we face in our community relations today?

Stanley W. Martin

Budget Responsibility

Financial problems arising from increasing operating costs are continually reflected in the expense statement. Obviously the major problem area here is the ever-increasing bill for salaries and wages. We all know many factors contribute to this condition, but what specific steps are we as administrators taking to utilize maximum controls in this area? Have we introduced some form of budgetary performance clearly understood and sympathetically supported by our department heads and supervisors? Good budget practice must involve all key staff personnel and requires supporting ingredients of cost accounting and accurate statistical performance records to achieve any useful purpose. The question has been asked, "How do you develop budget responsibility in department heads?" My personal opinion is that almost all humans require some sort of goal or measure of achievement to which they can work. But they like to have some say in determining such goals. Actually, intelligent forecasting of future performance based upon careful analysis of past experiences presents an interesting and exciting challenge to most people and if over-all objectives and purposes of budget planning are skillfully and enthusiastically explained to all involved, necessary objectivity and responsibility for supporting the program should result. If this is not possible, then perhaps we have failed to achieve a proper management or administrative outlook for our department heads and they are not really on our team. The budget is used as a guide and an aid in controlling costs. Not only are dollar figures involved, but also

(continued on page 114)

The "Why" Suggests the "How" in

Hospital-Intern Relations

Sidney Liswood,
Administrator,

George J. Riesz,
Administrative Assistant,
New Mount Sinai Hospital,
Toronto, Ont.

WE all know the importance of understanding, in fact, we would always like to be understood. But understanding both sides in a given situation is usually difficult. At New Mount Sinai Hospital, the internship and residency program has been developed on the basis that this relationship must be a reciprocal one and requires the full understanding of both the individual's needs and the hospital's objectives.

The intern working here or in any hospital has double motivation: he wants to learn and he wants to fulfil certain requirements for his professional status and advancement. The two motives may not be equally strong of course — some students notoriously concentrate on passing examinations instead of gaining knowledge—but both will exist and will have to be considered. The Canadian Medical Association's requirements* for approved internships recognize — and provide for—these factors.

Factors which frequently receive secondary consideration only are the interns' comfort, their reception, accommodation, orientation, and other minor but more tangible points which influence first impressions and affect attitudes and work relationships. Taking cognizance of these, the hospital has assigned an administrative assistant to make the necessary arrangements to meet these needs — which are largely administrative in character.

Preliminary planning started at meetings of the Intern and Education Committee. The members of this committee are representatives of all major clinical services, with the chief of one service acting as chairman. The administrator and the administrative assistant are invited to all meetings. The Committee can thus arrive at decisions and, simultaneously, agree on the principles to be followed by administration in implementing the decision. The most successful "activity" of the administrative assistant assigned to the interns is his presence and availability to interns in their first week of internship. Personal questions, such as choice of roommates and assignment of rotation schedules, could thus be solved within a few minutes, avoiding the development of minor requests or nuisances into real complaints or problems. These are then followed up by the assistant at periodic formal and numerous informal meetings with members of the house staff.

For continuity in this system of giving personal attention to each intern, and in order to encompass professional as well as other aspects, the medical staff has cooperated with the administration in establishing a preceptorship program. Preceptors, selected by the Intern Committee and approved by the Medical Advisory Council, will take over from the administrative assistant the guidance of the interns and thus provide, as well as obtain, information in a friendly manner, to enhance mutual understanding.

The preceptors are young men who will not find association with the "boys" difficult. They are chosen because of their professional attitudes, interest in professional relationships and education, loyalty to the hospital, and frequency of visits to the hospital. Excellent two-way communication is further facilitated by a co-ordinator of preceptors (a full-time physician), a chief resident (appointed) and by an elected president of interns.

On the other side of the picture, the hospital expects service and loyalty from the house staff. The administrator participates in the orientation program and, among other things, reviews clearly not only what the interns can expect from the hospital but also what will be expected of them, thereby setting the tone.

Orientation Sessions

The welcoming and introductory meeting was followed by a series of orientation sessions, again with the twofold purpose of introducing the new members to principles and techniques of our services to them and of their expected services to the hospital. Succeeding sessions were held under the guidance of the following personnel: Chairman, Medical Audit and Records Committee; Chief Admitting Officer, Communication Officer, Medical Record Librarian, and Pharmacist; and the chief of the Department of General Practice; and the Directors of Dietetics, Medical Social Service, Nursing, of the Out-Patient Department, Pathology, Physical Medicine, and Radiology; and a Public Health Nurse.

Evaluation

One of the important activities in intern education is evaluation of the individuals. Many of our interns will eventually apply for staff membership, others will want references for other positions. A simple form was drawn up to facilitate "marking" the interns, which at the same time helps the chiefs of services not only by preparing a formal written report for later references, but also by clarifying their own thinking on what they can and should expect from the interns. The points covered are by no means exhaustive, but they are usually sufficient to stimulate thinking. The "additional comments"

(concluded on page 58)

*"*Basis of Approval of Hospitals for the Training of Interns in Canada", the Canadian Medical Association, 1956.*

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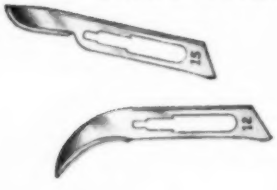

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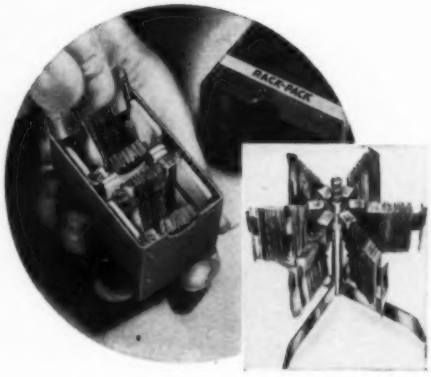

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Intern Evaluation Form

Service: *Surgery* Period of Service: *July-August-Sept., 1956*

Please evaluate the work of the interns who have completed their rotation through your department.

For your convenience, four questions are incorporated in this form, plus a blank column for any additional comment you would like to make.

The questions are: 1. Quality of professional work; 2. Interest in work of department; 3. Attendance at rounds, lectures, et cetera; 4. Ability to get along with attending and nursing staffs.

For the sake of consistency answers should be graded on the following scale: A—excellent, B—good, C—fair, D—mediocre, E—poor.

Intern:	Question: 1	2	3	4	Additional Notes
Albert, B. C.	....	....	....	....	.....
Cohen, S. D.	....	....	....	....	.....
Johnson, W. W.	....	....	....	....	.....
Smith, T. H.	....	....	....	....	.....

....

Date Signature of Chief

Intern Service Record

Name: *Smith, Thomas, Harry*

Date of Commencement: *July 1st, 1956*

Period:	Service:	1	2	3	4	Comments:
July, Aug., Sept.	*Surgery*	..	..	..	..	.....
October	*Emergency*	..	..	..	..	.....
Nov., Dec.	*Paediatrics*	..	..	..	..	.....
Jan., Feb., Mar.	*Medicine*	..	..	..	..	.....
April, May	*Obstet. & Gyn.*	..	..	..	..	.....
June	*Geriatrics*	..	..	..	..	.....

The questions are: 1. Quality of professional work; 2. Interest in work of department; 3. Attendance at rounds, lectures, et cetera; 4. Ability to get along with attending and nursing staffs.

Answers are graded on the following scale: A—excellent, B—good, C—fair, D—mediocre, E—poor.

Date of completion of internship: .....

Review of intern committee: .....

.....

.....

....

Date Signature

space frequently reveals valuable information, sometimes by giving the reasons for the grades set, sometimes by providing new clues to personal and professional traits.

The procedure for completion and filing of the evaluation forms is as follows:

The chief of each service is given an evaluation form with the names of the interns assigned at that time to his service. When these interns complete their rotation through that service, the chief returns the completed form to administration. The entries are then transcribed to the "Service Record" which is the record of the individual. At the end of the year, this form will have an entry from each chief through whose department the intern has rotated. This is then put into the intern's file (with his application forms, contracts, et cetera) and retained indefinitely.

In summary it may be said that recognition of multiple motivation, and of the different though compatible purposes, results in a happy atmosphere in which solutions to problems spring up almost automatically. Smooth communication channels, provided by a real desire for mutual understanding and good records ensure consistency and continuity in the program. ●

St. Mary's Hospital Wins Contest

It was announced recently that St. Mary's Hospital, Montreal, Quebec, is the grand award winner of the 1956 Hospital Safety Contest, conducted by the American Hospital Association and the National Safety Council, co-sponsors of the annual contest.

Designed to encourage the observance of safety practices among hospital employees, the contest was judged on the basis of the lowest number of injuries among employees of individual hospitals in relation to the number of man-hours worked during the year-long contest. The 215 hospitals participating in the contest reported more than a quarter of a billion man-hours worked, with a total of 2,124 injuries resulting in at least one day lost from work.

St. Mary's Hospital, with 425 employees, reported a total of almost 12 million injury-free man-hours worked during 1956, for a perfect record with the greatest number of injury-free hours among the participating hospitals.

Forty hospitals, or 14 per cent of the total reporting, had perfect records. Of these, half employed less than 100 people.

Commenting on the contest, Dr. Edwin L. Crosby, director of the American Hospital Association, said, "The winners are to be heartily congratulated for their efforts in emphasizing safety in their own hospitals and for their participation in this important contest which serves to call safety to the attention of all hospitals. Safety practices are a vital part of the over-all operation by which hospitals work toward their common goal, the provision of the best possible patient care."—*A.H.A. Press Information.*

Polio Vaccination in the U.S.A.

It is estimated that by July 1st, 1957, in the United States, 185,000,000 cc. of Poliomyelitis Vaccine will have been made available since the beginning of the vaccination program. There are some 109 million persons in the age group 0-40 in the United States. Estimates indicate that over 56 million persons have had one or more injections of the vaccine, 46 million of them among children and young people under age 20. Studies have shown that during 1956 about three-quarters of the paralytic cases occurred in persons under age 20. — *U.S. Public Health Service Release.*

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(continued from page 38)

qu'il est prudent de ne traiter que d'un seul sujet important par chaque lettre. Il est de même pour les rapports soumis au conseil par l'administrateur. Il est préférable, pour souligner les divers sujets qui seront traités, d'incorporer des sous-titres sous la rubrique "rapports du surintendant". On pourrait ainsi étudier individuellement chaque sujet au lieu de les considérer comme nombreuses parties d'un long rapport. Il est préférable que tout rapport important fait par le surintendant, à fin de présentation à une réunion du conseil, soit écrit. Il est facile de confondre plus tard ce qui est rapporté oralement. Ainsi le rapporteur est-il protégé par l'existence d'une copie écrite pour fins de référence et d'enregistrement. Tout hôpital, à l'exception des plus petits, comprend un service dactylographique pour taper les rapports. S'il n'y en a pas, on doit l'écrire à la main, au lieu de le faire verbalement. On ne doit pas oublier que les membres des conseils sont de gens occupés. Quand ils se rassemblent pour traiter des affaires de l'hôpital, ils doivent posséder, préparés d'avance et par écrit, des rapports précis et complets sur les diverses activités de l'hôpital qui seront discutées. Il incombe à une bonne administration de voir à ce que ces exemplaires soient fournies. Il est difficile de croire qu'une réunion du conseil puisse réussir si un programme n'est pas préparé d'avance et si les rapports sur les activités de l'hôpital ne sont soumis que verbalement. Un administrateur consciencieux consacre un temps abondant à l'organisation de la réunion du conseil. Il doit étudier d'avance toute question qui pourrait se poser, et voir à ce que tous les rapports, la correspondance, et la documentation nécessaires soient à la portée de la main. Une administration n'est pas compétente s'il faut que la discussion soit interrompue pour envoyer chercher des lettres ou des documents qui, avec un peu de prudence, auraient pu être rassemblés d'avance.

Le Nursing

LE numéro du mois d'avril de *Canadian Hospital* est consacré en grande partie au nursing, y compris des articles sur l'éducation et le service, l'administration, et l'accréditation d'écoles de nursing. A la réunion biennale tenue à Winnipeg en 1956, on a approuvé une étude préliminaire pour l'évaluation des écoles de nursing au Canada, l'évaluation étant considérée comme la première chose à faire avant d'atteindre l'accréditation d'écoles. A la page 42 du numéro d'avril, Frances McQuarrie, secrétaire d'éducation pour nursing de l'Association d'Infirmières Canadiennes, décrit les avantages d'un programme national et les démarches préparatoires faites par l'Association.

Aucun hôpital ne doit ignorer l'importance d'un service de nursing efficace dans la grande tâche de soin des malades. Il faut non seulement des gardes-malades en nombres suffisants, mais le niveau de leur éducation doit s'accorder avec nos temps. Suivant le concept de plus en plus répandu du traitement intégrale du patient—traitement physique et moral—et avec les exigences croissantes requises aujourd'hui des infirmières, il incombe à tout hôpital d'examiner continuellement la question d'éducation pour nursing. Les cours de revision sont d'une importance croissante puisque beaucoup d'hôpitaux comptent en partie aujourd'hui sur le service partiel d'infirmières, mariées et en demi-retraite, qui ont perdu, depuis quelque temps, contact avec la pratique moderne du nursing. Ce qu'un des hôpitaux a fait dans ce sens est décrit dans l'article du docteur F. P. Gordon de l'Hôpital Notre-Dame à North Battleford au Saskatchewan.

Quelqu'un a dit que s'il fallait choisir entre Hippocrate comme chirurgien et une graduée récente d'une de nos écoles de nursing pour le soigner, ou un chirurgien calé d'aujourd'hui et Sairey Gamp comme infirmière, il choisirait certainement le premier. La façon moderne de considérer le soin des patients dans l'hôpital d'aujourd'hui est un concept d'équipe où les gardes-malades jouent un rôle important.

A cause du fait que les infirmières sont le seul groupe que l'on peut toujours trouver à l'hôpital, à toute heure de la journée ou de la nuit, les fins de semaines ou les jours de vacances, il y a eu un mouvement progressif au cours des dernières décades, pour alourdir de plus en plus le service de nursing. D'une part, on parle du manque d'infirmières et cependant, on semble exiger qu'elles fassent continuellement de plus en plus. Quoique les infirmières doivent accepter ce fait comme un compliment à leur habileté et leur versatilité, cette charge est quelquefois très ennuyante.

Le thème de la dernière réunion biennale de l'Association d'Infirmières Canadiennes a été, "Ouvrez la porte à l'avenir", un but exprimé par Mary Agnes Snively dès 1908. Dans son message pour le Nouvel An, publié dans *Canadian Nurse* du mois de janvier 1957, la présidente de cette association, Trenna G. Hunter, a examiné le progrès du nursing, à la lumière de ce thème. Mlle Hunter est parmi celles qui croient que le nursing a fait beaucoup de progrès. Comme elle le souligne, on entendra toujours parler du bon vieux temps, des bonnes infirmières d'autrefois, mais, par contre, elle croit que l'on pourrait trouver autant de preuves qu'il y a des nurses consciencieuses, calées, bien éduquées et humaines aujourd'hui que dans le passé. Dans son article son argument est bien appuyé.

On reconnaît généralement, il me semble, que les infirmières font une contribution magnifique au soin des patients dans nos hôpitaux. Cependant, leur contribution trop souvent nous semble normale. Il est à espérer que les articles du numéro d'avril nous donneront tous une meilleure compréhension de l'administration du nursing, le service du nursing, et l'éducation pour le nursing comme il existe aujourd'hui dans nos hôpitaux.

Sécurité dans l'hôpital

LES accidents ne servent à rien. Ils sont évitables, gaspilleurs, et désastreux comportant souffrance humaine et perte de vie. Nous sommes tous d'accord sur ces idées—mais sommes-nous, tout de même, suffisamment prudents? On exige constamment des hôpitaux qu'ils soignent ceux qui sont blessés ailleurs —qu'est-ce qu'on peut dire concernant le nombre d'accidents dans nos institutions elles-mêmes?

L'élément de toute importance, dans cette ère mécanisée et tellement mobile, c'est notre attitude concernant les accidents et les mesures de sécurité prises pour les éviter. Il ne suffit pas que l'administrateur soit intéressé au compte des accidents dans son hôpital. La sécurité touche tout le monde! Il nous faut un programme bien étudié d'éducation pour la sécurité, dont le but serait de permettre à l'individu de travailler en suivant toutes les mesures possibles de sécurité. On doit toujours, en considérant un tel

(concluded on page 62)

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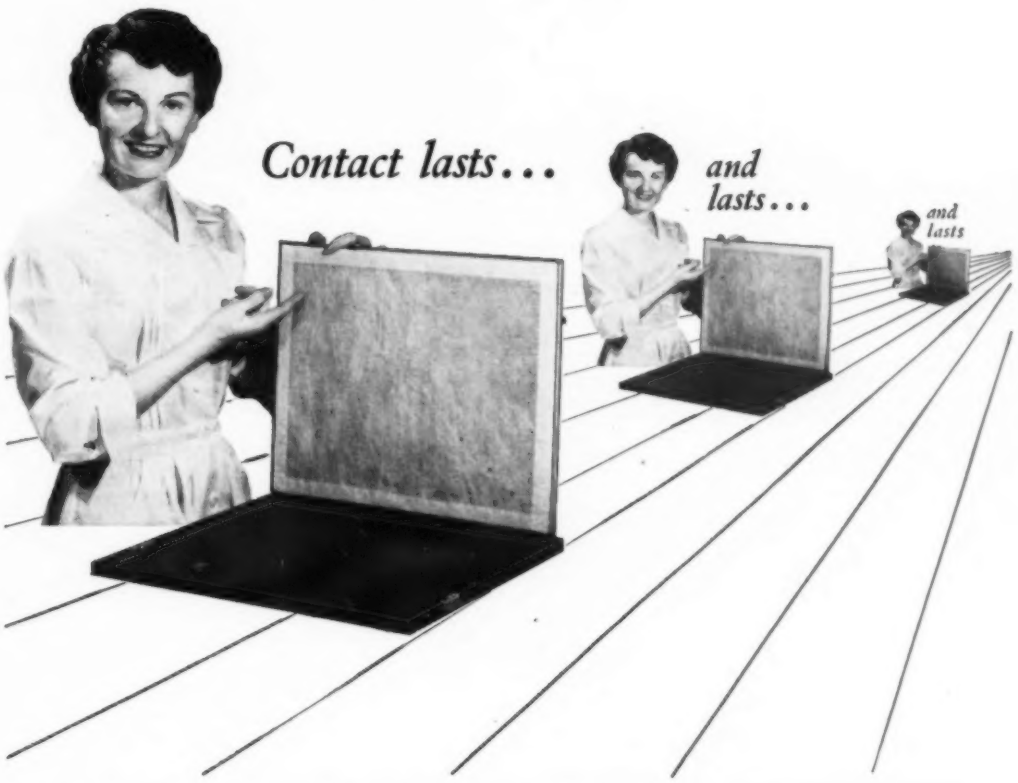

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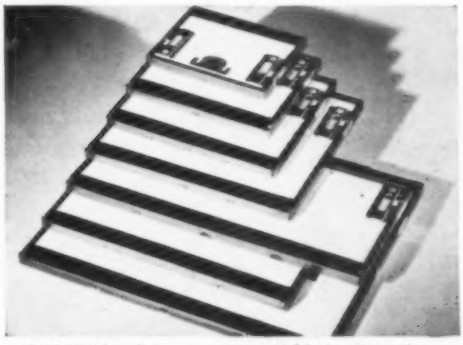

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(concluded from page 53)

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Lavoisier, Institut	Montreal
Maisonneuve, Hôpital	Montreal
Misericorde, Hôpital Général de la	Montreal
Montreal Children's Hospital	Montreal
Montreal General Hospital	Montreal
Montreal Neurological Institute	Montreal
Mount Sinai Sanatorium	Ste-Agathe-des-Monts
Notre-Dame, Hôpital	Montreal
Note-Dame de l'Espérance, Hôpital	Ville St. Laurent
Pasteur, Hôpital	Montreal
Queen Elizabeth Hospital of Montreal	Montreal
Queen Mary Veterans' Hospital	Montreal
Radium de l'Université de Montréal, Institut du	Montreal
Reddy Memorial Hospital	Montreal
Royal Edward Laurentian Hospital (T.B.)	Montreal
Royal Edward Laurentian Hosp.	Ste-Agathe-des-Monts
Royal Victoria Hospital	Montreal
Sacré-Coeur, Hôpital	Hull
Sacré-Coeur, Hôpital	Montreal
Ste Anne's Hospital (D.V.A.)	Ste Anne de Bellevue
St-Charles, Hôpital	St-Hyacinthe
Ste-Croix, Hôpital	Drummondville
St-Eusèbe, Hôpital	Joliette
Ste-Foy Veterans Hospital (D.V.A.)	Quebec
St-François d'Assise, Hôpital	Quebec
St. Georges Sanatorium	Mont Joli
St-Jean, Hôpital	St-Jean
Ste-Jeanne d'Arc, Hôpital	Montreal
St-Joseph, Hôpital	Granby
St-Joseph, Hôpital	Lachine
St-Joseph, Hôpital	Rimouski
St-Joseph, Hôpital	Trois Rivières
St-Joseph-de-Rosemont, Hôpital	Montreal
Ste-Justine, Hôpital	Montreal
St-Luc, Hôpital	Montreal
St. Mary's Memorial Hospital of Montreal	Montreal
Hôtel-Dieu St. Michel & Sanatorium	Roberval
Saint-Sacrement, Hôpital du	Quebec
Ste-Thérèse, Hôpital	Shawinigan Falls
St-Vincent-de-Paul, Hôpital Général	Sherbrooke
Lac Edouard, Sanatorium du	Lac Edouard
Ross, Sanatorium	Gaspé
Sherbrooke Hospital	Sherbrooke
Shriners Hospital for Crippled Children	Montreal
Verdun, Hôpital Général de	Montreal
Youville, Hôpital	Noranda

Saskatchewan

Canora Union Hospital	Canora
Fort Qu'Appelle Sanatorium	Fort San
Holy Family Hospital	Prince Albert
Moose Jaw Union Hospital	Moose Jaw
Prince Albert Sanatorium	Prince Albert
Providence Hospital	Moose Jaw
Regina General Hospital	Regina
Regina Grey Nuns' Hospital	Regina
St. Elizabeth's Hospital	Humboldt
St. Joseph's Hospital	Gravelbourg
St. Joseph's Hospital	Macklin
St. Paul's Hospital	Saskatoon
St. Peter's Hospital	Melville
St. Thérèse Hospital	Tisdale
Saskatoon City Hospital	Saskatoon
Saskatoon Sanatorium	Saskatoon
University Hospital	Saskatoon
Victoria Municipal Hospital	Prince Albert
Yorkton General Hospital	Yorkton

Obiter Dicta

(concluded from page 60)

projet, prendre en considération trois groupes—les patients, les employés, et le grand public.

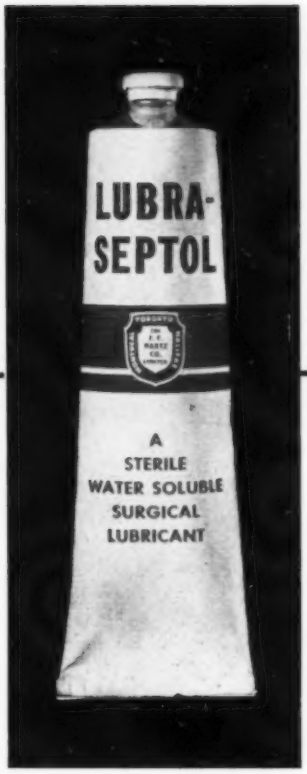
Il n'existe pas d'hôpital trop petit pour avoir un programme actif de sécurité. Dans un hôpital de capacité réduite, l'administrateur en prendra charge personnellement et sera directement intéressé à la formation de la programme et la surveillance de son exécution. Le surintendant dans un hôpital plus grand peut déléguer cette autorité à l'administrateur-adjoint, au directeur de personnel ou à l'ingénieur-en-chef. Qui que ce soit qui dirige le plan, son succès dépendra en grande partie de l'attitude des chefs de services et du personnel de surintendance.

Il ne suffit pas que votre hôpital satisfasse les conditions fondamentales en donnant de la protection contre les dangers de feu, les infections contagieuses, et les chutes, ou qu'il soit préparé à combattre les défaillances d'électricité ou un désastre possible dans la communauté. Il ne suffit pas non plus que l'équipement soit scientifiquement installé, adéquatement maintenu, examiné régulièrement, et correctement utilisé. Les ouvriers doivent, en plus, connaître et suivre les méthodes standardisées d'opération; ils doivent savoir comment agir en cas d'urgence et juger que, pour la sécurité, la bonne administration est de rigueur.

Beaucoup d'hôpitaux ont trouvé avantage à établir un conseil de sécurité. Pour assurer le bon fonctionnement de ce groupe il faut fournir certaines informations statistiques. Celles-ci doivent inclure le nombre de malades qui subissent des chutes à l'intérieur de l'hôpital, le nombre d'employés qui subissent un accident, sérieux ou minime, et les accidents subis par les visiteurs à l'hôpital. Il est évident que tout accident, même le moins important, doit être enregistré. Seulement par la révision périodique de ces rapports peut-on savoir si on fait de véritables progrès.

Il ne suffit pas seulement d'établir un conseil et de garder des registres. Il est de première importance d'instruire les employés dans l'exécution de leur travail. On ne doit pas oublier qu'il y a de fréquents déplacements du personnel, et que chaque nouvel employé a besoin d'orientation, d'instruction et de surveillance. L'entraînement pour la sécurité est une partie fondamentale de tout programme d'orientation et d'éducation pendant la période d'instruction-service de l'employé. Le travail de continuation est essentiel, et comprend l'inspection, bien organisée, de conditions et de méthodes de travail. Prenons tous la résolution de faire de 1957 une année où toute l'organisation se rendra plus consciente des mesures de sécurité.

. . ."and it's easy on the Budget"



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Parisian Air at Charity Ball

A Parisian café, with songs and dances of that gay city highlighted the sixth annual charity ball held under the auspices of Cornwall General Hospital Women's Auxiliary to raise funds for hospital aid and services in Cornwall, Ontario. To the familiar rollicking music of Offenbach, a bevy of beauties presented the well-known Can-Can in traditional full-skirted black and red costumes. Supporting the chorus numbers were cigarette girls and men from the famous Left Bank. Songs and skits as well as a floor show added to the festivity of the occasion.

* * * *

New Auxiliary In Portage La Prairie

Formation of a St. John Ambulance Auxiliary in Portage la Prairie, Manitoba, planned for many months, was finalized in January. It is made up of a number of ladies with St. John home nursing training to maintain close contact with the local hospital. In the event of emergency such as a train wreck, severe highway accident, or a disaster which would give rise to the need for a civil defence authority intervention, they would be of invaluable use in the hospital. They would know the location of various items of equipment and also the procedure of the hospital.

* * * *

Hospital Lift

Gift of the Women's Hospital Aid, a modern hydraulic lift, a device for handling bed patients in moving them from bed to chair, was given recently to the Saint John General Hospital, Saint John, New Brunswick. It is particularly useful on the convalescent floor where most of the patients are elderly.

* * * *

Holiday Cruise Held by Auxiliary

A south sea cruise provided inspiration for the ladies of the St. Mary's Hospital Auxiliary of Montreal, P.Q., in planning a gala event in aid of its social services. The entrance of the hotel was transformed into a dimly lighted pier, and crates, ropes, and trunks all helped the illusion. The guests descended a gang-plank into the ship. Passengers were all given excursion to shore passes in order that they might re-embark. They walked down the Promenade Deck with its port holes, deck chairs and life preservers giving the effect of a modern ship deck. When the ship reached Jamaica, calypso players came aboard to entertain the guests.

* * * *

Spring Fair and Tea

A calendar fair and tea held on March 15 was a most successful affair. This is a yearly project of the Colchester County Hospital Ladies' Auxiliary, Truro, N.S., and hundreds of ladies from Truro and surrounding districts donned their new spring bonnets to attend the social event of the year.

The auditorium was most attractively arranged with spring flowers everywhere and on the tea tables were found novelty arrangements pertaining to the various months of the year. Colourful booths added greatly to the decor.

* * * *

Paging System

A paging system, or public address system, was installed recently in Grace Hospital, St. John's, Newfoundland. The money was raised during 1956 by the Grace Hospital Women's Auxiliary through such activities as a take-home turkey tea in May and a jumble sale in June. The newly installed system has outlets on each floor of the hospital and nurses' home.

* * * *

Special Bus for Veterans

Plans are under way to provide a special bus for veterans at the Colonel Belcher Hospital, Calgary, Alberta, through the Ladies' Auxiliary. It was agreed that the veterans, especially the newly-arrived convalescents, needed additional trips for recreational and therapeutic purposes, which would be too costly if hired transportation were used. The bus will accommodate from 25 to 30 passengers. Half the seats will be removable, allowing room for veterans' wheel chairs. Double doors and a built-in ramp at the rear of the vehicle are other special features. It has been revealed that the Department of Veterans' Affairs canteen will donate $50 per month toward maintenance costs.

* * * *

Children's Chapel

One of the most novel chapels in Montreal, P.Q., was dedicated in February, at Montreal Children's Hospital where St. George Kiwanis Club has provided an amenity suitable for Protestant, Catholic and Jewish faiths. The tiny chapel with pews for 32 worshippers and space for wheelchair and bedridden patients has a rotating platform with separate altars for the three faiths. The platform is mounted on rubber-tired wheels and will be swung into appropriate positions for regular services in each faith.

* * * *

Workshop Latest Project

The new workshop at King George Hospital, Winnipeg, Manitoba, is the latest project of the Princess Elizabeth Hospital Guild, which serves all three municipal hospitals. Equipment donated by the guild to the workshop included a saw and motor, sander and motor and special sewing machine. John Petro, who is in charge of the workshop, is making self-help gadgets and devices for handicapped patients. It is hoped in the future that the patients will work and train there.

* * * *

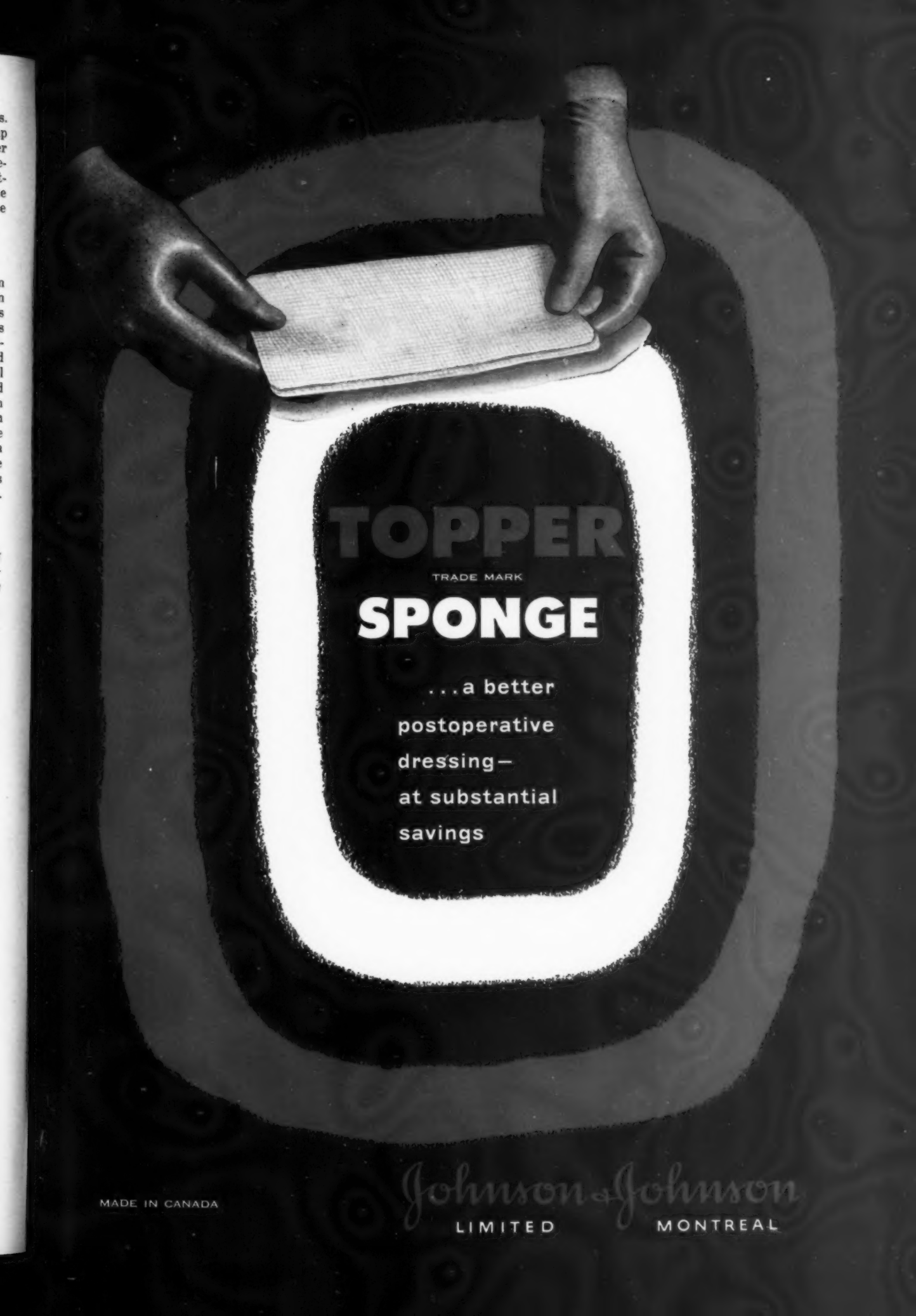
A Paying Proposition

The auxiliary of Terrace and District Hospital, Terrace, British Columbia, have operated a Thrift Shop for the past two years and reports are that they netted $1,584 from it in 1956. At present it occupies an old building which has been loaned to them, but now the auxiliary is putting up a "small but modern" building of their own which they hope to use for their meetings as well.

* * * *

Youngest Auxiliary Yet

The Auxiliary of the Royal Edward Laurentian Hospital, Montreal, P.Q, has a new group in the Town of Mount Royal known as "The Little Sisters of the Alexandra Hospital Unit." It is made up of eight girls between the ages of 11 and 13.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Provincial Notes

New Brunswick

The new Tobique Valley Hospital, south of Plaster Rock, recently opened, will serve approximately 5,000 residents in the towns and districts of the Tobique River Valley. Capacity of the brick structure is 22 adult beds in addition to four for children and six bassinets. There are also x-ray, paediatric and radiology departments, quarters to accommodate 12 nurses, kitchen, laundry, boiler room, dining room, out-patients department and elevator. The hospital is in part the result of a community effort over a three-year period.

Quebec

Officials of the Hôpital Ste-Justine building fund announced recently that this Montreal hospital will celebrate its 50th anniversary this year by moving into new modern quarters within a few months. The new hospital will rank among the most modern and best equipped children's medical centres, training schools, and research laboratories in the world. Five of the hospital's nine floors will be devoted to patient rooms located in wings radiating from a central core. Rooms which older children will occupy are equipped with oxygen and intercommunication outlets. Infant quarters are four-sectioned rooms, each equipped with wash basin, temperature-controlled linen closet and two-way windows. The building is heated by radiant heat pipes in the ceilings so that dust circulation will be reduced, and covering of children at night will be of lesser importance. Insulation in the first two floors make it possible to convert them to bomb shelters for 2,500 persons.

The provincial government will spend $8,000,000 in the coming fiscal year to build mental hospitals. Among the projects is a hospital in Joliette, already started, another one in Annonciation, to begin soon, and increased facilities in Baie St. Paul.

Ontario

Plans for hospital expansion to be carried out in five stages over the next ten years are in line for Port Arthur General Hospital, Port Arthur. A program for funds begins this spring.

Also a campaign for funds is taking place at Milton for the new Milton District Hospital with a capacity of 50 beds. It is being built with provision for a possible extension to an eventual 200-bed unit. The hospital will serve Trafalgar and Nelson townships, as well as the town of Milton.

Work on the new section and the rebuilding of St. Mary's Hospital, Timmins, is also reported to start this spring. Another fund campaign was opened for an expansion of St. Bernard's Convalescent Hospital, Toronto, which is operated by the Missionary Sisters of the Precious Blood.

Plans were recently submitted for the building of an extension to the Centre Grey General Hospital, Markdale. It will be a one-storey structure built as a separate unit immediately behind the present building and will hold 24 beds with allied services.

An important event took place in northwestern Ontario recently with the opening of the modern Dryden District General Hospital, Dryden, overlooking Lake Wabigoon.

Manitoba

Construction on a one-storey addition to Grace Hospital, Winnipeg, starts this spring and will comprise 28 adult beds, 30 bassinets, operating and case rooms.

The new interns' quarters of the Winnipeg General Hospital offer modern accommodation for 86 persons. Along with private rooms for the interns, they feature a variety of relaxation and entertainment facilities. For 38 years, a former isolation building across from the hospital has been home to the interns.

Payment of the final instalment of a $50,000 government grant to the Alcoholism Foundation of Manitoba is expected to enable it to conclude negotiations for the establishment of a treatment centre for alcoholics. The building will house an out-patient clinic where counselling services will be available to alcoholics and their families and where superficial medical treatment will be administered. Patients who require more intensive medical care will be treated at hospitals. Both the Winnipeg General and St. Boniface Hospitals have offered to provide beds for alcoholic patients.

Saskatchewan

Hospital building is in various stages of development in this province. Work on a three-storey addition to the Swift Current Union Hospital, Swift Current, and construction of a nurses' residence which will house 79 nurses, begins this spring. The project will cost $500,000. Present capacity of the hospital is 114 beds and 39 bassinets. The new wing will add 41 more beds. Room for additional pathological services will be provided in the section on the main floor now occupied by the children; while the new children's ward will be established on the third floor of the new structure.

In the new residence, besides accommodation for the regular nursing staff, there will be quarters for the superintendent of nurses, and also for the house mother. A property, formerly a part of the Kiwanis park area, will provide space for the building.

Changes are also planned for Weyburn Union Hospital, Weyburn, in the form of alterations to the heating and ventilating system, painting and further landscaping of the grounds.

The new LaFleche Union Hospital, LaFleche, is situated in beautiful landscaped grounds which were donated for the eight-bed hospital just on the outskirts of the town. The exterior of the building is of the most modern design and finish, while wide corridors, well-lighted rooms, acoustic walls and ceilings, and the rest of the interior of the institution show the latest in engineering design.

Tenders for construction of an addition to Brock Union Hospital at Arcola have recently been received.

(concluded on page 68)

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SYMBOL OF QUALITY Beiersdorf

Provincial Notes
(concluded from page 66)

Alberta

Construction on the $305,000 chronic convalescent hospital in Camrose has passed the half-way mark. The 50-bed hospital being erected in the southeast section of the city by the Evangelical Lutheran Church of Canada, will be completed this summer.

Growth and expansion in the city and surrounding area of Wetaskiwin have created crowded conditions and although extensions have been built in the past 25 years, the facilities of the present 63-bed Wetaskiwin Municipal Hospital are considered inadequate and most departments are crowded. A proposed 30-bed, two-storey addition is expected to be added to the east end of the present hospital and will include two operating rooms on the first floor as well as recovery room, x-ray room, laboratory, kitchen, dining room and doctor's lounge. The main floor will accommodate a waiting room and 30 beds, six of which will be in private wards. Total cost of the wing is estimated at $450,000.

British Columbia

Hospital building is taking place or about to begin in various sections of this province. Plans have been ordered for new hospitals by the Hope and District Hospital Association in Hope and by the Williams Lake Hospital Board in Williams Lake. Preliminary plans have also been prepared for a new 30-bed hospital building at Golden. St. Joseph's Hospital, Victoria, seriously overtaxed with increasing numbers of patients in all departments, plans to build a new maternity wing to ease overcrowding.

Gorge Road Hospital Board is planning a service for rehabilitation of patients in a proposed 20-bed addition to the present 104-bed hospital, as the result of a BCHIS ruling extending insurance coverage to the chronically ill. The hospital is operated now mainly as a nursing-care centre for elderly patients, although it was built and equipped for treating chronic cases. Benefits will be extended to patients regardless of age requiring hospital care but not the services of an acute hospital.

Snow and arctic weather have failed to halt work on the new $910,000 Campbell River and District Hospital, under construction on a five-and-a-half-acre site donated by the village of Campbell River, and completion date is set for June. The hospital will have 60 beds, provision for an additional storey and will command a fine view. Tenders have just been called for the nurses' home.

A modern, two-storey, 63-bed hospital of reinforced concrete construction, for which tenders were recently received, will be built at Maple Ridge in the Fraser Valley.

Canada's newest and most easterly Red Cross Outpost Hospital is located at Carbonear, Newfoundland.

Shetland's War Memorial

The Shetland War Services Commemorating Committee recently decided that Shetland's War Memorial is to take the form of a rehabilitation centre in the new hospital to the built at Lerwick.—*The Hospital*, March 1957.

Save suture handling with D & G SURGILAR* Sterile Pack

GET BROKEN GLASS OUT OF THE O.R.

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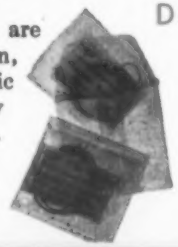

photo technic: *light-tracings of hands to which bulbs are attached.*

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You Were Asking . . .

Several administrators were asked to answer the following question: *During the year, what social and recreational activities are undertaken by your hospital for your staff?* The answers received are as follows.—*Edit.*

St. Rita Hospital, Sydney, N.S.

FOR THE staff as a whole, professional and non-professional combined, a Christmas party, sponsored by the hospital, is held each year. A committee selected from the staff directs the evening's program which consists of games, music and dancing, with Santa Claus distributing gifts to all. Lunch is served.

A second function in which all categories of staff participate is an annual program for the feast of St. Rita, patroness of the hospital, on May 22nd. The day begins with Mass in the hospital chapel, which the majority of the staff attend. A special feast day menu is planned and all are given a "free" luncheon and dinner (ordinarily staff meals are obtained at the pay cafeteria). A varied program is arranged for the afternoon or evening. Last year, this consisted of two showings of "Green Years", a two-hour film.

Staff dances are sometimes held at the hospital. These have been initiated by the staff themselves, and they select their own committees for program, refreshments, et cetera. A small admission fee is charged, which covers expenses incurred.

Occasionally, an invitation is extended to the staff to attend a variety concert or a play put on by the students of the school of nursing.

Besides these activities for the staff as a whole, some categories of personnel participate in programs with others of the same status in the vicinity. For instance, there is the Nurses' Memorial Day Observance each year, when our nursing staff join with nurses of nearby hospitals and local nurses' guilds, in a joint program, consisting of a parade to a selected church where a conference and benediction are given. Following this a social evening is held, with a program of entertainment, arranged by the local nurses' guild. Refreshments are served, catering being done by the hospital auxiliary.

Similarly, for the past two years, laboratory technicians from all hospitals in the area have a joint Christmas party, with usual entertainment. The staff technicians of the host hospital arrange for program and tea.

A greater number of staff activities would be desirable; but, owing to the fact that all our paid personnel must "live out", it is difficult to get the group together for any sustained social or recreational program.—*Sister M. Clarissa, Supt.*

Red Deer Municipal Hospital, Red Deer, Alta.

THE recreational hall at our hospital is a community centre for the staff. Here we hold our square dances, our annual Christmas-tree party, bridal showers for departing staff members and the monthly meeting of the Alberta Association of Registered Nurses. All these functions draw new members of the staff together and at the same time introduce them to former nurses who are now homemakers in town.

A few years ago the hospital board erected a barbecue in a secluded spot on the hospital "back" lawn. It is a popular centre on summer evenings for entertaining and devouring tasty barbecued foods.

During the summer months the hospital board rents a cottage at Sylvan Lake. Days off, week-ends and free evenings are spent at the lake. All types of outdoor activities are offered. Highlights include chicken fries and steak suppers, when the girls may invite their friends to join in the fun.

Formal dances sponsored by the nursing staff number two or three annually. Invitations are sent out to numerous residents of the district, who join with the nurses and their friends to make very enjoyable evenings. The staff spirit is jovial during the preparations for the frolics.

Many of the staff are sport fans. Often they hike two miles from the residence, after a shift of duty, to play nine holes of golf. Plans are in the making for a hospital ball team.

A happy staff member, we have found, works harder and has a better relationship with her patient.—*Katherine Macalister, Matron.*

Yellowknife District Hospital Inc., Yellowknife, N.W.T.

OUR community is probably unique in the fact that there is so much going on one hardly knows where to start.

Our hospital of 40 beds with staff of 24 is in a mining community of approximately 3,000 people. The mining camps, within taxi distance, have recreation halls with bowling, badminton and dance clubs, to which they very kindly invite our staff. There is also a badminton club in the public school in town which anyone may join.

Our golf course is a sand course five miles from town but there is never any problem of transportation during the summer season.

The hospital is situated on a small lake which affords very good swimming from a sand beach, only ten minutes walk away. There is a tennis court, of sorts, in the park adjacent to the hospital.

There are always kind friends who want to know when you are having a day off, so they can arrange a boating or fishing trip up the Yellowknife river. On occasion, there have even been plane trips to small lakes in the district, for fishing. Who could ask for more!

During the winter we have skating and curling, the rinks only being five minutes walk from the hospital. The staff themselves have organized skating parties and several of the staff curl.

As you see there is no lack of opportunity for recreation.—*Mary C. Murphy, Matron.*

Plummer Memorial Public Hospital, Sault Ste. Marie, Ont.

WE DO not have a very extensive social and recreational program for the staff at this hospital. However, the following is a resumé of our actual small functions, during an average year, to which staff members are invited.

1. During February each year the ladies' auxiliary sponsors an annual ball and of course all hospital people are invited to attend.

(continued on page 72)

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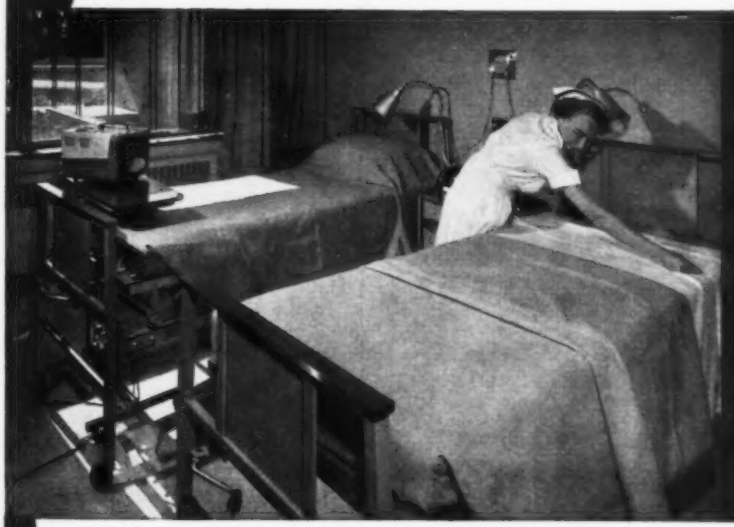

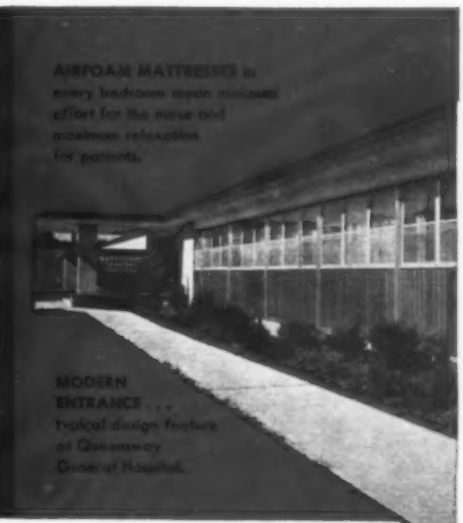

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You Were Asking

(continued from page 70)

2. Various films, both educational and recreational, are shown during the year in our main dining room for the staff as a whole, followed by lunch and a social hour.

3. Card parties with the usual lunch are periodically arranged during the winter season.

4. The hospital invites all staff members to both the capping exercises, usually late in February, and the graduation exercises in June. On both of these occasions a social hour with lunch follows.

5. At the Christmas season a full Christmas dinner with all the trimmings is provided free of charge.

6. And finally a Christmas-tree party, where gifts are exchanged is held in the recreation room for all students and graduate nurses, a few days before Christmas. This is a most enjoyable occasion and much appreciated by all. The students usually present a Nativity play with appropriate Biblical scenery, dress and sacred songs and music.

Some years ago a tennis court was built on the grounds and equipment provided. A few of the staff nurses seemed to enjoy it for the first season, after which it fell into disuse and was finally removed to make way for the hospital extension.

New nurses are usually given special attention to make sure that they get into the swim, as it were, and all seem to be very happy.—*A. G. Middlemiss, Adm.*

St. Mary's Hospital,
Kitchener, Ont.

THE following is a synopsis of the social and recreational activities of the staff during an average year.

1. In the early fall of each year the students of St. Mary's School of Nursing hold their "Autumn Twirl", a semi-formal dance. All members of the staff are invited.

2. When the excitement of the students' fall dance cools, the Nurses' Alumnae Association holds a very informal dinner and social, usually called the "Harvest Hoedown". Staff members enjoy a gay social evening together.

3. An annual Christmas concert and party is held in the week before Christmas. It is held in the Nurses' Residence. Usually Santa pays the staff a visit. The students present a variety of amusing skits, together with a Nativity scene and musical numbers, et cetera. Then we sing, dance and enjoy a delicious lunch in the latter part of the evening.

4. A separate program is arranged for the medical staff at their December meeting. Turkey with trimmings is served, before a short concert given by the nurses.

5. The nursing staff is also treated to a turkey dinner at Christmas.

6. In February, at "capping", the educational and supervisory staff are guests of the students at the capping ceremony and their reception later which is sponsored by the hospital.

7. Graduation, usually taking place in May, is a day of festivity for the hospital staff as well as for the graduating class. Members of the staff are invited to the formal exercises in the afternoon, and at night, the graduation dance—semi-formal—provides an excellent opportunity for celebration.

8. The Nurses' Alumnae Association sponsors a dinner for the graduating class annually. The hospital staff is always invited.

The Ladies' Auxiliary and the Nurses' Alumnae Association also sponsor teas and card parties during the year. Then, we have the usual run of farewell parties, bridal showers and so forth, which may not include the whole staff, but which are encouraged by the directors of the hospital, for they help to maintain a good spirit among the hospital personnel.

We are planning hospital extension in the near future and hope to increase facilities for more in-service education and recreation.—*Sister M. Paula, Dir. of Nursing and Principal.*

Yarmouth Hospital,
Yarmouth North, N.S.

OUR SCHOOL of nursing has very few regularly scheduled social or recreational activities. However, we do encourage the students to take the initiative in organizing dances, wiener roasts, corn boils, et cetera. Refreshments and food are supplied by the hospital.

The formal annual activities are receptions following the two capping ceremonies when relatives and friends are invited to a buffet supper. A dinner is also given to graduating classes and the invitation list includes board members and wives, medical staff and wives and executive members of the hospital staff. On the evening following the graduation exercises a formal ball is arranged. The Ladies' Aid assist in the payment of expenses for these functions.

At Christmas time parties are arranged for the various sections of the hospital staff. Maids and maintenance, student nurses and their instructors, graduate nurses, aids, orderlies, technicians and office staff form the three main divisions. A traditional Christmas dinner is provided for all the staff on duty.

Shortly after joining the school a party or get-together is arranged for the new students. This enables the girls to meet various members of the hospital staff.

I believe this covers the main items of activities other than educational which is more or less routine during the average year at our hospital.—*E. O. Hodge, Adm.*

North Bay Civic Hospital,
North Bay, Ont.

THE planned social and recreational activities for the staff are not extensive for the following reasons:

(a) North Bay is a popular centre for outdoor sports. In summer there is camping, swimming, fishing and hunting and in winter skiing, skating, hockey and curling.

The local recreational council conducts two 14-week courses of instruction in square dancing each season which is very popular with members of our staff.

(b) The graduate nurses represent the largest individual group of our staff. Most of these are married women, resident in the city and its environs, who have home and family responsibilities. Consequently they have neither the time nor the need for organized recreation or social activities. The unmarried graduate nurses are mostly residents of the city and live at home.

(c) A separate area of our hospital building serves as a nurses' residence but it accommodates only eight. It is sufficiently large and isolated to afford private living accommodation but does not have space for recreational activities except for small social gatherings of those in residence and their immediate friends.

The following are the staff functions during the year to which the employees as a whole or in groups are invited:

1. The graduate nurses hold a

(concluded on page 74)

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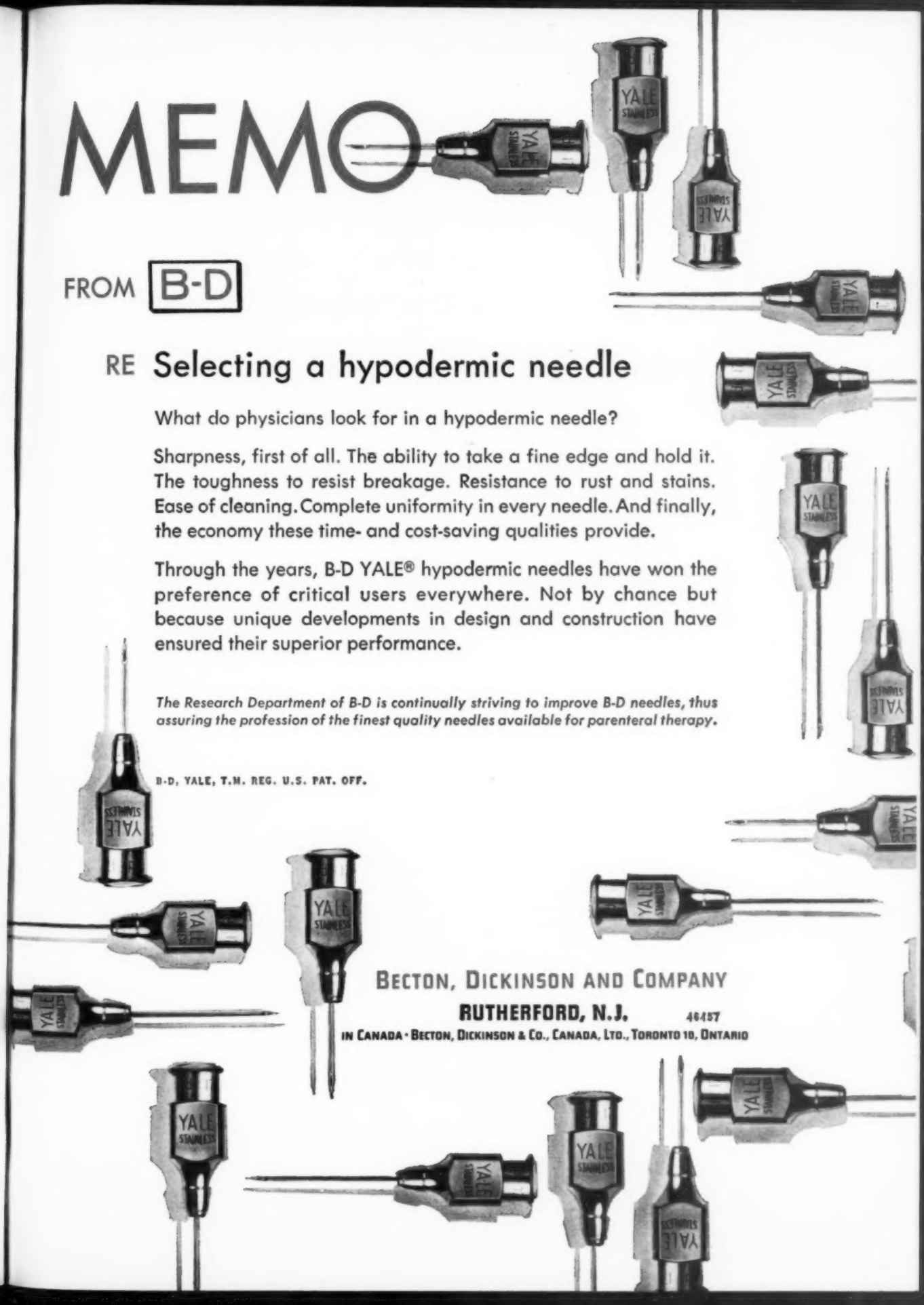

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You Were Asking

(concluded from page 72)

dinner to which all graduates are invited.

2. Small social gatherings are held during the year for members of the staff who are to be married or are leaving the employ of the hospital. These take the form of a tea and presentation held during the afternoon coffee-break in the main dining room, and are attended by representatives of all departments.

3. On the occasion of the fifth anniversary of the opening of the new hospital, employees who had completed five or more years of continuous service were presented with five-year pins at the June meeting of the Hospital Commission by His Worship, Mayor M. E. Dickerson.

Later in the year these employees and others who, during the interval, had completed their five years of service were guests of the city at a banquet when further presentations of pins were made. This banquet was attended by the five-year employees, their guests, and all members of the Hospital Commission with their wives or husbands. The Mayor, his representative on the Commission and another alderman were present and each addressed the meeting briefly.

4. The highlight of the year is the annual Christmas-tree party and dance for all employees, which is sponsored by the Hospital Commission. All employees are invited and each may bring a guest. Each employee, whether able to attend or not, is invited to exchange a gift with another employee. There are attendance and spot-dance prizes and the Christmas gifts are distributed by "Santa Claus". This is always a very enjoyable occasion and much appreciated by the staff.

These social gatherings play an important part in the life and work of employees in our hospital.—*Howard W. Smith, Adm.*

Skill in Menu Planning

An adequate, satisfying meal is not a thing to be taken for granted. It doesn't just happen but is achieved by careful and intelligent planning together with wise buying. The foods on the menu should be intelligently chosen, skillfully prepared, and attractively served whether they are on the patients' trays, the pay cafeteria counters, or the helps' dining room. And if you have never had a pay cafeteria for visitors and employees, why not consider establishing one? It will cut your food and service costs and there is no law against your making a little profit.

In order to do this proper choosing of menu materials, good food preparation, and nice serving, the menu maker must know what the market offers, what the patients and employees will eat, what her equipment will handle, and what her kitchen staff can prepare.

It is important to buy on the wholesale level and in wholesale packages. Every time you have a wholesale package broken, it costs you money as the price always goes up per unit. In the early days of a small hospital, sometimes local buying at retail is done, either because of a desire to patronize local retailers who have perhaps contributed money toward the building of the hospital or because of ignorance. Buyers should have had training in buying, not just experience which may lead one to keep right on making the same mistakes.—*Mabelle S. Ehlers, Southern Hospitals.*

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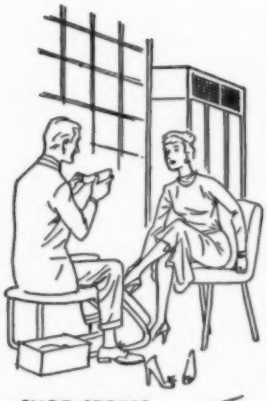

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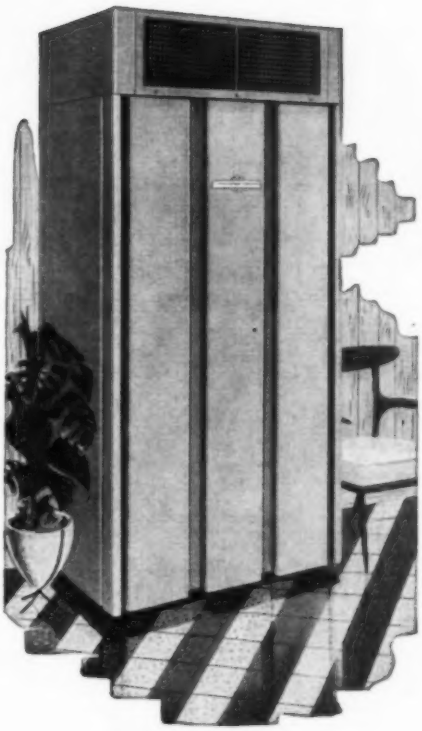

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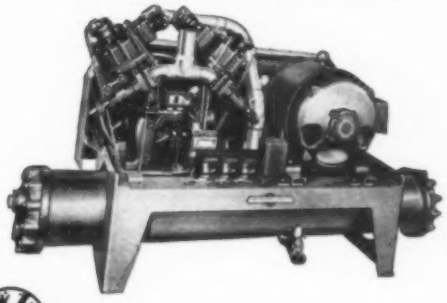

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Oh Facts, Oh Figures!

Margaret Glynn,
Medical Record Librarian,
Queensway General Hospital,
Toronto, Ont.

Query: Do you employ a medical record librarian?

Hospitals Reporting	Number of Beds	M.R.L's	Not Reg.	No Librarian
41	under 100	14	7	20
44	100 to 199	26	6	12
22	200 to 299	18	2	2
11	300 to 399	8		3
8	400 to 499	8		
9	500 to 599	9		
5	600 to 699	4	1	
9	700 to 799	8		1
2	800 to 899	1		1
3	900 to 1000	2		1
7	1000 and over	5		2
161		103	16	42

Query: How are diseases and operations indexed?

Hospitals Reporting	Number of Beds	S.N.D.O.*	I.S.C.**	Misc. Classif.	Not Indexed
25	under 100	14	1	6	4
33	100 to 199	25		4	4
22	200 to 299	21			1
9	300 to 399	7			2
7	400 to 499	7			
9	500 to 599	8		1	
5	600 to 699	5			
7	700 to 799	7			
2	800 to 899	2			
2	900 to 999	2			
6	1000 and over	5		1	
127		103	1	12	11

*Standard Nomenclature of Diseases and Operations.
**International Statistical Classification.

Query: Do you feel that these indexes are used by your medical staff sufficiently to warrant the time and knowledge required for their compilation?

Hospitals Reporting	Number of Beds	Yes	Doubtful	No
42	under 100	12	3	27
44	100 to 199	13	1	30
22	200 to 299	9	2	11
11	300 to 399	6		5
8	400 to 499	4		4
9	500 to 599	4		5
5	600 to 699	5		
9	700 to 799	5		4
2	800 to 899	1	1	
3	900 to 999	3		
7	1000 and over	7		
162		69	7	86

AT THE Second International Congress on Medical Records in Washington, D.C., Oct., 1956, a panel group discussed diagnostic classifications and indexes. Although a Canadian representative was not participating in this panel, it was felt that it would be useful for Canadians attending to have statistical information concerning numbers of librarians, the diagnostic classifications in use, the indexes based upon these, and on the frequency of use of these indexes. In order to be aware of existing conditions throughout Canada, and also of the thinking of the administrative staffs of Canadian hospitals, we circularized our hospitals and obtained statistics which are summarized herewith.

As would be expected, the smaller hospitals had a lower percentage of medical record librarians and yet, surprisingly, some hospitals of 700 beds and over were operating without medical record librarians.

Diagnostic indexes are being maintained in the majority of hospitals. Even so, there are large hospitals where diseases and operations are not indexed and this applies rather frequently to the smaller hospital group. One-half of the hospitals canvassed feel the indexes are not used sufficiently by the medical staff to warrant the time and knowledge required for their compilation and yet this is not a general opinion among the larger hospitals.

Standard Nomenclature is used pretty well throughout with about one-third of this group also using International. Only in the smaller hospitals, 300 beds and under, is another type of nomenclature in use. About one-seventh of the hospitals agree that doctors do not use terminology suitable for Standard Nomenclature; over one-half had no comment whatsoever on this subject.

The majority of hospitals seem satisfied with their present systems, with about one-quarter of the smaller hospitals contemplating changes. This section contemplating change could be part of that group striving to meet the mini-

(concluded on page 78)

Compiled by the author at the request of the Canadian Association of Medical Record Librarians. Of the nine schedules of data prepared as a result of this survey, three of the most pertinent are shown here. See also Canadian Hospital, September, 1956, p. 136.—Edit.

FOR OPERATING ROOM USE

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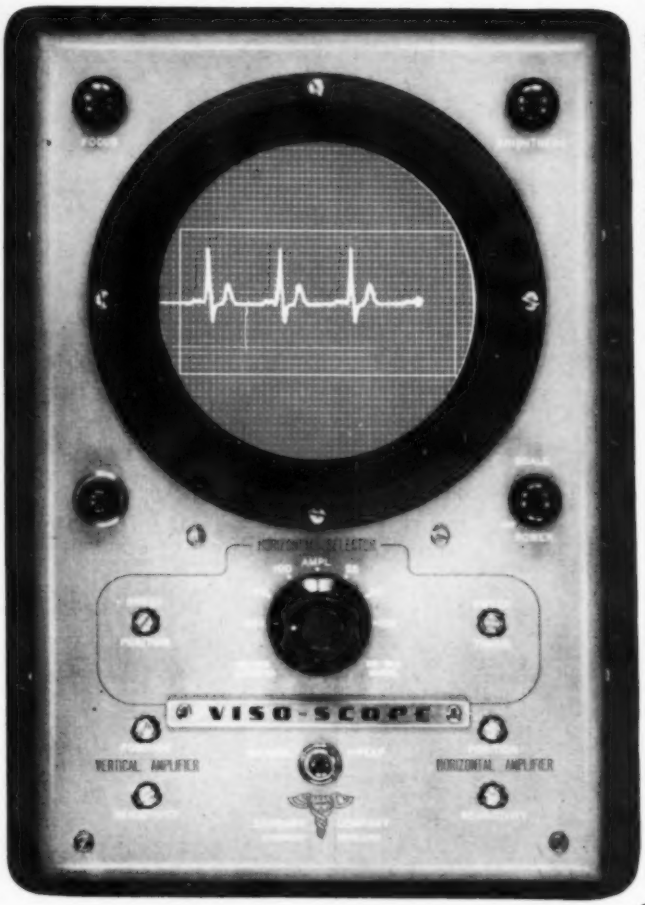

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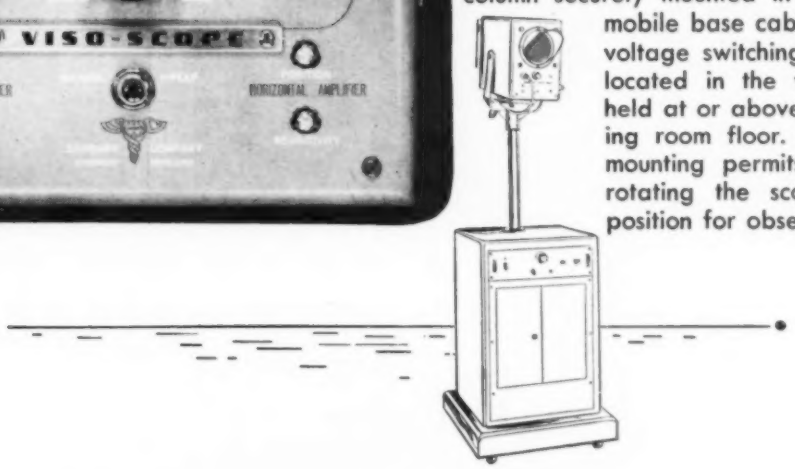

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mum requirements of the Joint Commission on Accreditation of Hospitals, who state: "The Standard Nomenclature should be used as a nomenclature and it is preferred if medical records are coded".

It would seem logical to presume that accredited hospitals or hospitals desirous of obtaining accreditation are those hospitals maintaining diagnostic indexes and using the Standard Nomenclature of Diseases and Operations.

What, then, is being done in the small percentage of large hospitals who do not maintain a diagnostic index and are not using Standard Nomenclature?

Medical record librarians are in the position today of being able to make a very worthwhile contribution to medical science and research by their scrutiny of the chart for its contents and completion, their attempts to get their charts signed, completed and filed, their interest and enthusiasm which acts like a magnet to draw the doctors to the medical record office and their willingness to do research and detail work to aid the doctors in their projects and clinical staff meetings.

In view of the important rôle of each individual librarian, the Canadian Association of Medical Record Librarians, with the aid of the statistics which we have compiled and evaluated, cannot over-emphasize the necessity for training more medical record library personnel in order to have the indexes, so important for study and research of our medical staff, available.

Then the small as well as the large hospitals will benefit by the progressiveness shown by our profession and thus aid in the education of the hospital staff and benefit mankind.

World Federation for Mental Health Plans August Meeting

The tenth annual meeting of the World Federation for Mental Health will take place in Copenhagen, Denmark, from August 11th-17th, this year by kind invitation of the Landsforeningen for Mentalhygiejne (The Danish Society for Mental Hygiene).

The main theme will be "Growing up in a Changing World". Special attention will be given to such matters as the effects of social welfare services on the family, the prevention of juvenile delinquency with reference to the work of the children's courts, child guidance work, relationships between parents and children, school psychological services, and what "a changing world" means in different countries of the world.

Enquiries should be addressed to the Secretary-General, World Federation for Mental Health, 19 Manchester St., London, W. 1, England. —*RNAO News Bulletin.*

Coming Conventions

May 24-25—Board of Directors, Canadian Hospital Association, Bessborough Hotel, Saskatoon, Sask.

May 26-30—Canadian Society of Laboratory Technologists, annual convention, Astor Hotel, Vancouver, B.C.

May 27-June 1 — Canadian Hospital Convention, Saskatoon, Sask. (The 14th Biennial Meeting of the Canadian Hospital Association, combined with the 12th Western Canada Institute for Hospital Administrators and Trustees). The biennial meeting of the National Council of Women's Hospital Auxiliaries of Canada will be held concurrently in Saskatoon.

May 27-29—Canadian Public Health Association, annual meeting, Toronto, Ontario.

May 27-30—Catholic Hospital Association Convention of the U.S.A. and Canada, Hotel Statler, Cleveland, Ohio.

May 29-June 4—Quadrennial Congress of the International Council of Nurses, Rome.

June 3-7—International Hospital Congress, Lisbon, Portugal.

June 8-13—Second Joint Convention, American Society of X-ray Technicians and Canadian Society of Radiological Technicians, Sheraton Park Hotel, Washington, D.C.

June 12-14—Canadian Dietetic Association, annual meeting, Chateau Frontenac, Quebec, P.Q.

June 17-21—Canadian Medical Association, annual meeting, Macdonald Hotel, Edmonton, Alta.

June 17-21—A.H.A. Nursing Service Administration Institute, Chateau Laurier, Ottawa, Canada.

June 18-21—Maritime Hospital Association, annual meeting, Algonquin Hotel, St. Andrews, N.B.

June 24-26—Comité des Hôpitaux du Québec, convention-exhibition, Montreal Show Mart, Montreal, P.Q.

June 25-28—Canadian Tuberculosis Association, annual meeting, Vancouver, B.C.

August 11—Canadian Society of Hospital Pharmacists, annual meeting, Montreal, P.Q.

Sept. 29—American College of Hospital Administrators, annual convocation, Convention Hall, Atlantic City, New Jersey, U.S.A.

Sept. 30-Oct. 3—American Hospital Association, annual convention, Hotel Traymore, Atlantic City, N.J.

Oct. 15-18—British Columbia Hospitals' Association, Hotel Vancouver, Vancouver, B.C.

Oct. 22-24—Associated Hospitals of Alberta, convention, Provincial Auditorium, Edmonton, Alta.

Oct. 28-30—Ontario Hospital Association, Royal York Hotel, Toronto, Ont.

Oct. 31-Nov. 1—Ontario Conference of the Catholic Hospital Association, St. Michael's Hospital, Toronto, Ont.

Nov. 11-15—Institute on Housekeeping, King Edward Hotel, Toronto, Ont.

Nov. 14-15—Operating Problems of Small Hospitals, Bessborough Hotel, Saskatoon, Sask.

uate key jobs; (4) Evaluate the remaining jobs.

It is worth noting that the work of evaluation which has been described is done by a committee. Each member of the committee does his own evaluation and the final result is the average of the individual evaluations.

Which is Best?

Which method is best? They all have advantages and disadvantages. A difficulty with the ranking method is that usually there is no one in an organization who knows jobs well enough to be able to rank more than a few of them. The principle is sound, however, and this method is used by some technicians as a check on results obtained by other methods.

The classification method is sound. It is used in many state governments in the United States. In Canada it is used by the governments of Manitoba and Saskatchewan and a classification plan is now being set up by the government of Alberta. Critics say that the classification method is too rigid, that it is not sufficiently objective, and that it leaves too much to the judgment of technicians.

In industry factor-comparison and point-evaluation are in common use and some authorities claim that they are superior. But since it may be necessary to pay more money for a given job than for another job with a higher evaluation and since labour market values may change although factor-comparison or point-evaluation values remain the same, critics say that these methods are more rigid than classification and that much of the claimed objectivity and exactness is more apparent than real.

It is likely that the validity of an evaluation depends more on how well the work was done than on the method which was used. A great deal has been written and said about scientific methods of job evaluation. One company has claimed that its point-evaluation plan is so scientific and exact that it leaves no room for judgment. Such a statement, of course, is preposterous. At some stage in any method of job evaluation, you must leave the realm of verifiable fact and enter the realm of judgment. No job evaluation can be more valid than the judgments which produced it and judgment has not yet been reduced, or perhaps I should say elevated, to the status of an exact science.

We have now reached the stage at which, if the classification method is used, jobs have been divided into families and assigned to certain classes or levels within each family, and if factor-comparison or point-evaluation is used, jobs have been arranged in order of their difficulty and importance. With respect to the latter, unless there are to be as many salary ranges as there are jobs it is necessary to establish point grades.

Procedure

I am going to describe the procedure followed by one company which uses a point-evaluation method. It is the experience of experts in this field that greatest satisfaction is achieved when the point maximum of one grade is equal to the geometric mean of the grade next above it and to the minimum of the grade second above it and when the range from minimum to maximum is from 20 per cent to 35 per cent. The company in question picked a 25 per cent range and developed the following formulae:

1. The point maximum of a grade is equal to the minimum multiplied by 1.25.
2. The point maximum is equal to the geometric mean multiplied by the square root of 1.25.
3. The point minimum is equal to the geometric mean divided by the square root of 1.25.

The point value of the least important job in the company was 49 which was taken as the geometric mean of the lowest point grade. Using formulas 2 and 3 the point minimum and point maximum of the grade were found to be 44 and 55 respectively. Similarly, the minima, geometric means and maxima for other grades were calculated as shown in this table.

Grade	Point Minimum	Selection Minimum	Geometric Mid-Point	Selection Maximum	Point Maximum
1	44	46 & below	49	52	55
2	49	52 (53)	55	58	61
3	55	58 (59)	61	65	68
4	61	65 (66)	68	72	77

You will notice that the grades overlap so that you wouldn't know whether a job with a point score of 50 should go in grade one or grade two. To get rid of this overlap, geometric means were calculated as shown in columns two and four of the table. Some overlap remained, however, because the maximum of each grade was equal to the minimum of the next higher grade. Raising each minimum by one point eliminated all overlap and made it possible to assign each job to a point grade.

Schedule

Before the wage administration plan emerges a wage schedule or compensation plan must be constructed to which job classifications or point grades may be fitted. In building a salary schedule experts recommend the procedure used to establish point grades except that overlapping does not have to be eliminated. In addition, there is considerable agreement that a schedule should have 30 to 60 wage grades and that at each level there should be a range of four to six steps with a constant percentage of about five per cent between them. The 30 or more wage grades will cover the wage spread from top to bottom in an organization. The four to six steps at each level, protests of proponents of the single rate to the contrary notwithstanding, provides flexibility and holding power, and a five per cent increase from step to step represents a sufficient incentive for promotion. If the percentage increase from grade to grade is the same as from step to step in the grade, an interlocking schedule will result, i.e., the rates in any grade will be the same as the minima of the next succeeding number of grades.

With the classification method anchor jobs, preferably the highest and lowest in each class are assigned to appropriate grades after comparison with rates in the labour market. The intermediate classes are then fitted in between. When factor-comparison or point-evaluation are used anchor jobs are used together with existing or prospective rates of pay or rates in the labour market. If pay for the lowest grade job is related to the appropriate range in the pay schedule, the bottom of the schedule is defined and it is a simple matter to assign the

(concluded on page 84)

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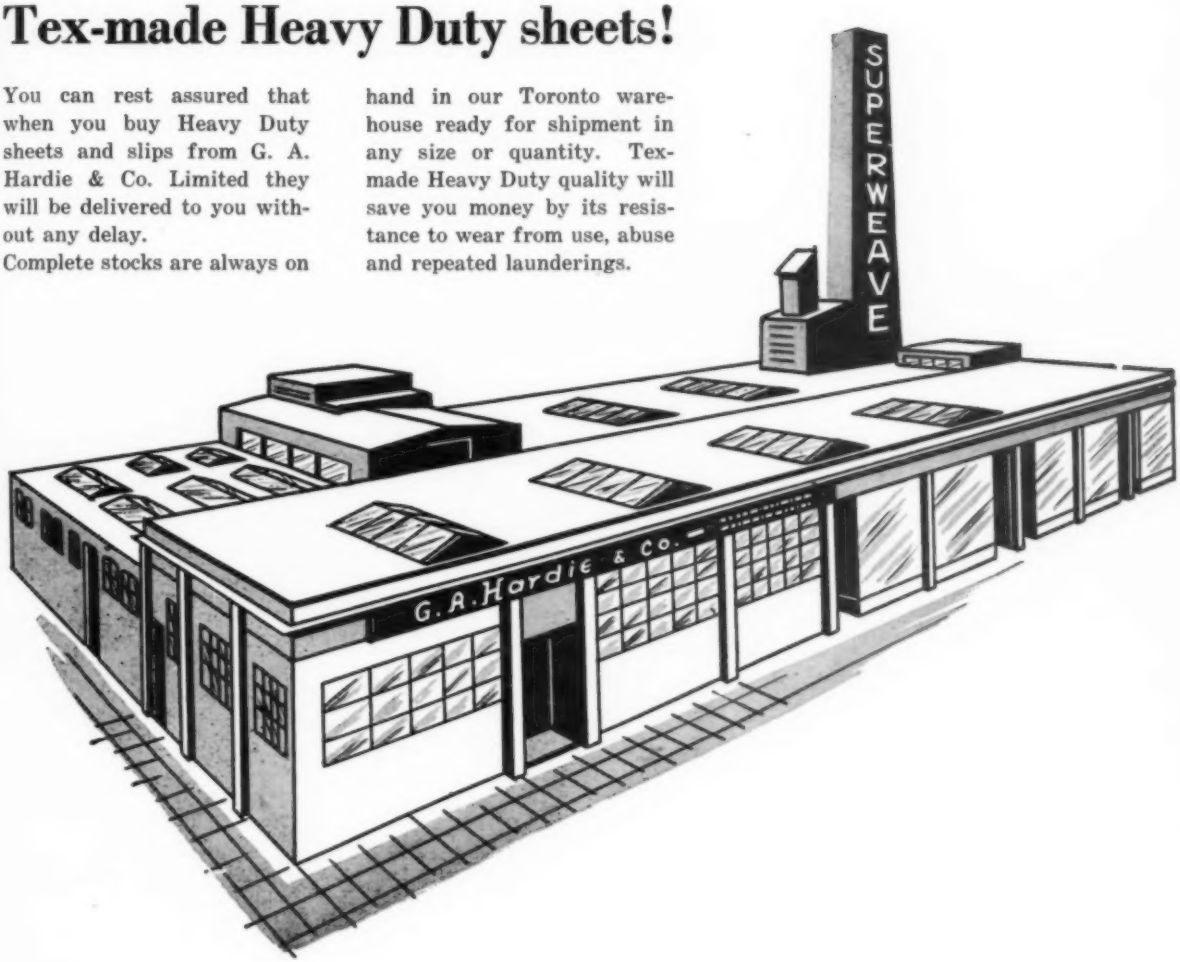

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Good Wage Structure

(concluded from page 80)

second lowest point grade to the second wage range, et cetera, until every job has been allocated. If good judgment has prevailed in every department of the work, the result will be a pay plan that has internal consistency, the most difficult and important job having the highest pay range and the least difficult and important having the lowest pay range.

Validity

The final step is to validate the pay plan by comparison with the labour market which requires a wage survey. Descriptions of key, benchmark or anchor jobs, together with a questionnaire, are sent to employers in the area to be surveyed. The descriptions are important because unless information returned refers to comparable positions it will be useless. It is important to obtain information about a sufficiently large number of each kind of job to give validity to the result. By making a graph of the survey information, and comparable data from the pay plan the relation between the two can be seen. At this point wage policy must be determined. The employer must decide whether he is going to pay below average or above average rates. He must decide whether the wage scale will be determined absolutely by formula or whether at some point the formula will be modified to prevent the increments from becoming too large and salary rates too high. For example, if a constant percentage increment of 5 per cent has been used the employer may decide that at a certain salary level it will be reduced to 4 per cent in order to keep the wage bill within the ability of the company to pay. He must decide in what way and to what extent fringe benefits will be taken into consideration. He must decide what to do with jobs which, according to the draft of the wage plan, would be overpaid or underpaid, and he must decide what to do with jobs in those areas where recruiting is difficult. As the result of these practical considerations it may be necessary to modify or adjust the pay plan.

Although you have listened to a good deal of theory, certain principles of wage administration are either explicitly or implicitly included in what I have said. To be a satisfactory device for determining fair and equitable compensation a wage administration plan must (a) be sound and easily understood; (b) recognize that the evaluation and compensation plans are separate and distinct from each other; (c) provide for flexibility in both the rating and the compensation plans; (d) be consistent with the policies and objectives of management; (e) be understood and accepted by employees; (f) meet local requirements; and (g) satisfy public interest.

In conclusion, I want to recapitulate. Wage and salary administration means putting the right price tag on each job. Since every employer must administer wages he had better, in his own interest, do as good a job as possible. The supporting pillars of a good wage structure are: (a) Job descriptions; (b) Job evaluation; (c) A wage schedule; (d) A salary survey; and (e) Wage policy.

Food and Drugs Act

(continued from page 51)

lation, such as I have just defined, brings into the limelight many questions that may have been recognized for years, but for which positive resolution has not been forthcoming. Sound legislation thus stimulates research, for we now need to know positively, for instance, what *are* the bacterial toxins that can be found in foods. We have already isolated several. In the light of confusion in the literature, what was the dependability of specific tests for food-poisoning toxins? Did other substances give false tests? What kind of substance is a toxin? How many varieties are there? Could we isolate and purify them, and hence find how they act and perhaps devise faster, less costly, and surer methods of detecting and assaying them? We now know that the staphylococcus food-poisoning toxin, which is responsible for about 80 per cent of the food-poisoning recognized on this continent, is a distinct entity different from all associated staphylococcus toxins. We believe it to be a specific protein which must be extremely active biologically, for it requires less than 0.001 milligrams of an impure preparation of this protein to make a monkey sick. We believe we have characterized it sufficiently by use of infra-red spectrophotometry to be able to detect the toxin in specific extracts from culture-filtrates or from foods.

Other Questions

There are many other questions we are concerned with as a result of this legislation. Can we find bacterial species comparable to the coliforms (that indicate faecal contamination) which are indicative of other objectionable aspects of contamination with spoilage or of public health significance? Moreover, what about the antibiotic-resistant strains of bacteria we find in foods? How important are they? Where did they come from? We now have experimental data that lead us to suggest that the antibiotic - resistant staphylococci, which we found to occur at the ratio of about 30 per cent in market cheese, occur as a result of the use of antibiotics in widespread fashion for the treatment of mastitis among the dairy herds. Some of these strains are highly toxigenic and their property of antibiotic resistance may impose a severe secondary problem. We must reach decisions, too, on how important or unimportant are some of the other bacteria that traditionally have been considered objectionable. Further, for what length of time will potentially harmful bacteria remain alive in foods? Is there a rationale for expecting value from antitoxins or antisera against food-poisoning? Our immediate finding on this is somewhat disconcerting because we know that the enterotoxins from different strains of *staphylococcus* are antigenically distinct and, therefore, the use of a general antiserum or antitoxin against them is unlikely to be of more than limited value. About food-poisoning, too, we want to know what conditions are conducive to toxin formation. What conditions inhibit formation of or destroy the toxin? Further, what is a clean surface bacteriologically speaking? What is the value of microbiological standards? What would be a valid standard for specific foods or for factory surfaces? What are the potential hazards that may result from changing processing prac-

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Food and Drugs Act

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tices? How widely can pathogenic bacteria be disseminated by a contaminated food? As a partial answer to this, we have proved that a specific food-poisoning strain of staphylococcus isolated at a particular cheese factory, could be recovered as the dominant staphylococcus strain in the marketed product from that particular factory, when examinations were made from ten different collections of that brand of cheese from each of eight different cities ranging from Halifax to Vancouver. This occurrence offers powerful argument for proper sanitary control because the implication of hazard is quite obvious should a serious pathogen or toxin be introduced into a widely distributed food. Many more questions will arise. Independent laboratories and industrial associations are already organizing to solve some of them.

However, the exact determination of scientific data is only one of our obligations. These are the facts which we must marshal before reaching decisions that ultimately become expressed through law. At times these decisions are of such perplexity that our executives who recommend them must find the responsibility trying indeed. May I illustrate the sort of thing I have in mind by referring again to a topic on which I was asked to express a summation of fact and opinion as guidance to our Directorate. This was on the question of whether it was in the interests of consumers to recommend the inclusion of a particular antibiotic as a preservative in fish. A well-documented brochure was submitted by the interested company. This particular submission, being the first of its kind, if allowed would obviously establish something in the nature of a precedent. How wise would it be to establish such a precedent? This sequence illustrates the care with which decisions of this kind are made. It is the kind of sequence in which the Canadian consumer, and in particular those who have professional interest in the quality of our foods, might well be interested.

The antibiotic was chlortetracycline. This was what we wanted to know about it in the interest of the Canadian consumer before being prepared to recommend a revision of existing regulations to allow its inclusion in fish.

1. What evidence that chlortetracycline offers any advantage over or is at least equivalent in effectiveness to chemicals presently allowed and what are the precise advantages claimed?

2. What evidence that chlortetracycline (CTC from now on) has significant bacteriostatic effect at the temperatures at which the food would normally be stored, namely, at cold storage temperature?

3. What evidence that the disturbed ecology of contaminants would not induce new spoilage problems by allowing development of species normally held in check by the present numerically predominant forms? This question would arise from the observation, frequently encountered, that when a selective anti-microbial agent is introduced to foods, while it may inhibit the growth of specific segments of the total bacterial population, others, through lack of competition, may be encouraged and spoilage of a type not com-

(continued on page 88)

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Food and Drugs Act

(continued from page 86)

monly found may develop.

4. What assurance can be given that the use of a preservative such as CTC will not encourage poor sanitation and processing hygiene which already present a substantial problem?

5. What steps or provisions are considered by the submitting company as a safeguard against such an eventuality, as just expressed?

6. What provisions are intended to prevent abuses through the use of excessively high concentrations or by providing a source secondarily available to persons other than those officially concerned in its use?

7. To what degree may resistance to CTC be induced among human pathogens?

8. What is its specific effect in the inhibition or conversely, a stimulation, to those pathogens and food-poisoning organisms known, on occasion, to be associated with these foods?

9. What is the toxicity of any residual chlortetracycline? Would prolonged accumulation or use of this substance lead to accumulative or chronic toxicity?

10. When CTC disappears after a time in foods, or during cooking, what are the breakdown products from it? One of these is said to be a substance known as iso-chlortetracycline.

11. What evidence is available that iso-chlortetracycline has no toxicity, and

12. What effect if any, can this residue have on inducing antibiotic resistance in bacteria significant to man?

13. Further, to what degree could the continuous use of CTC lead to the development of resistant strains of fish flora, as a result of prolonged contact in transport and processing? We have in mind, of course, that the inducement of highly resistant food spoilage organisms could create problems worse than those already understood, and opportunities for the development of fairly high concentrations could occur through evaporation after splashing and drying out or from local accumulations in the bilges of holds of ships or in pipelines, pumps, work surfaces, or the clothing of workers in ships or fish plants.

14. To what degree would continuous exposure on the part of fishermen and factory workers induce an allergic sensitivity to this substance?

15. What were the proposed additives to be used in any formulation in which this substance was the active ingredient?

16. What evidence that CTC was not carcinogenic, or in an animal or person normally resistant to specific sarcomas, could it stimulate the growth of such sarcomas? Space will not permit a listing of the data "pro and con" for each of these items, but since this substance is now tolerated as a preservative in fish under specific conditions, you may be assured that all of these queries were satisfactorily answered, though, as is true for all regulations, in the event that new evidence should accrue suggesting that the decision was unwise, then appropriate steps would be taken for modification or repeal.

One point I want to emphasize is, that no organization in this field can offer or maintain leadership without a well-equipped and well-staffed research laboratory which must become the "work-shop" of the scientific consultants. The cost

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of research and scientific investigation today points more and more inevitably to the rôle of government in research, particularly in aspects of public health. It is my personal conviction that the primary aim of a federal organization in the field of food-control and of factory sanitation should be one of leadership, for which we must earn a position of prestige by thoroughness of attainment and diplomacy in our interrelationships. I feel quite positive, too, that wise use of the power of the new Food and Drugs Act will allow us to make substantial contributions to this forward advance by collaboration with and perhaps even stimulation of other agencies. It is our obligation to interpret the Act in an attitude of realism and to make it effective through an educational system tied to impartial punitive action whenever undue fault persists.

I would ask you to view these observations in the light of what I believe in sincerely, and what I regard as basic Food and Drug Policy, namely, that control action under law should be governed by

the cardinal principle that regulation with legal force is only tolerable if the regulation earns a significant degree of success in its objectives which, in turn, must be of some public benefit. In these exacting objectives, something of a personal philosophy convinces me that our success will be enriched by demonstrating an awareness of the theme, revived by the contemporary philosopher Overstreet, to the effect that mainly by working together do people inch along towards learning to think together—surely a prerequisite to the tripartite liaison which must develop, namely, a collaboration between government services—federal, provincial and municipal—with industry and with the consuming public in whose behalf the Food and Drugs Act is constituted. This is the "climate" we strive to establish in our objective to assure that the foods, drugs, and cosmetics sold to all Canadians shall indeed be safe, wholesome, and ethically advertised.

Body Operates Own Sleep Regulator

Whether sleep comes in naps or longer stretches, apparently eight hours of it daily is just about what the body needs. Latest scientific evidence of this was given to the British Association for the Advancement of Science at a meeting in Sheffield, England, by Drs. H. E. Lewis and J. P. Masterson, of the Medical Research Council, Hampstead, London.

They reported tests made on members of the British North Greenland Expedition during the continuous nights of the Arctic winter. The men were permitted to sleep when they liked and practically as long as they liked. "During the dark period", commented the scientists, "members were going to bed and taking naps at all times over the 24 hours, and one was given the impression that they were sleeping excessively". Yet when sleep was totalled up for the month, members of the expedition averaged 7.9 hours a day—almost precisely the reputed need.—*Scope Weekly.*

Humour is emotional chaos remembered in tranquility. — *James Thurber.*

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Employees' Point of View

(concluded from page 47)

a contribution to the rest of society, are entitled to some of the considerations that the rest of society enjoys in the way of a reasonable living standard.

The trade union movement is an institution which today is a recognized, respected part of the Canadian way of life. It is here to stay and it is here to stay in the hospital field. But to make progress in our relationship, don't just tolerate the union—accept it.

Bases for Wages

What are the various factors that establish the bases for wages and conditions of hospital employees? The answer to this question could well be found in the April 1st, 1956, issue of *Hospitals* in an article by Ray E. Brown, a professor at the University of Chicago. His opinions to a large degree coincide with our own. One of the main factors in establishing the bases for wages is the increasing national productivity of the over-all working force of Canada, or of America, if you like. That over-all, ever-increasing productivity, which is on a basis of roughly 3 to 4 per cent per annum, has a reflection on all wage structures. Fortunately or unfortunately, again, whatever your point of view, to a large degree we must be able to consume what we produce in Canada. And to be able to buy what we produce, we must have the wherewithal to pay. You cannot peg or restrict the standard of living of one group of employees—and I am referring to British Columbia hospital employees when I say this—without doing the same with other groups, for there is a relationship between hospital workers and all other workers. The over-all economic activity in Canada eventually reflects itself in the operation of hospitals.

Another aspect, though a not too accurate one, is the community average—what is paid for similar or like employment in any given area or territory. To define what is similar employment, to make accurate comparisons of job descriptions of hospital employees with job descriptions in industry and the outside, is a difficult undertaking, unless you have all the factors before you.

Hospital wages will continue to rise, whether it be in the form of real wages or relative wages, as long as gains are being made by the rest of the working force in Canada. We lack much that is a cost factor to industry. We have no unemployment insurance, no adequate pension coverage, in other words, no general over-all social security. And as long as our economy is expanding, so will the economy of hospitals expand, as the largest proportion of hospital expenditures is salaries and wages.

I have often been asked when will this spiralling end? When will all these wage increases come to an end? I feel the answer is simple. When will the world stop going around? When will evolution end? The world never stands still. We may on occasions have reverses, but we always progress eventually. Hospitals must march hand in hand with science and general progress.

Red Cross in Wartime

The International Committee of the Red Cross is the traditional intermediary in time of conflict. The ICRC was founded almost 100 years ago.

Twenty Years Ago

("The Canadian Hosiptal", May, 1937)

The formal opening of St. John's Convalescent Hospital, Newtonbrook, Ontario, is arranged for Saturday, May 22nd, at 11 o'clock in the morning. His Excellency the Governor General, has kindly consented to perform the ceremony. Meanwhile, private patients are being received and plans are being made with the Public Hospitals for the transfer of patients to the Convalescent Hospital.

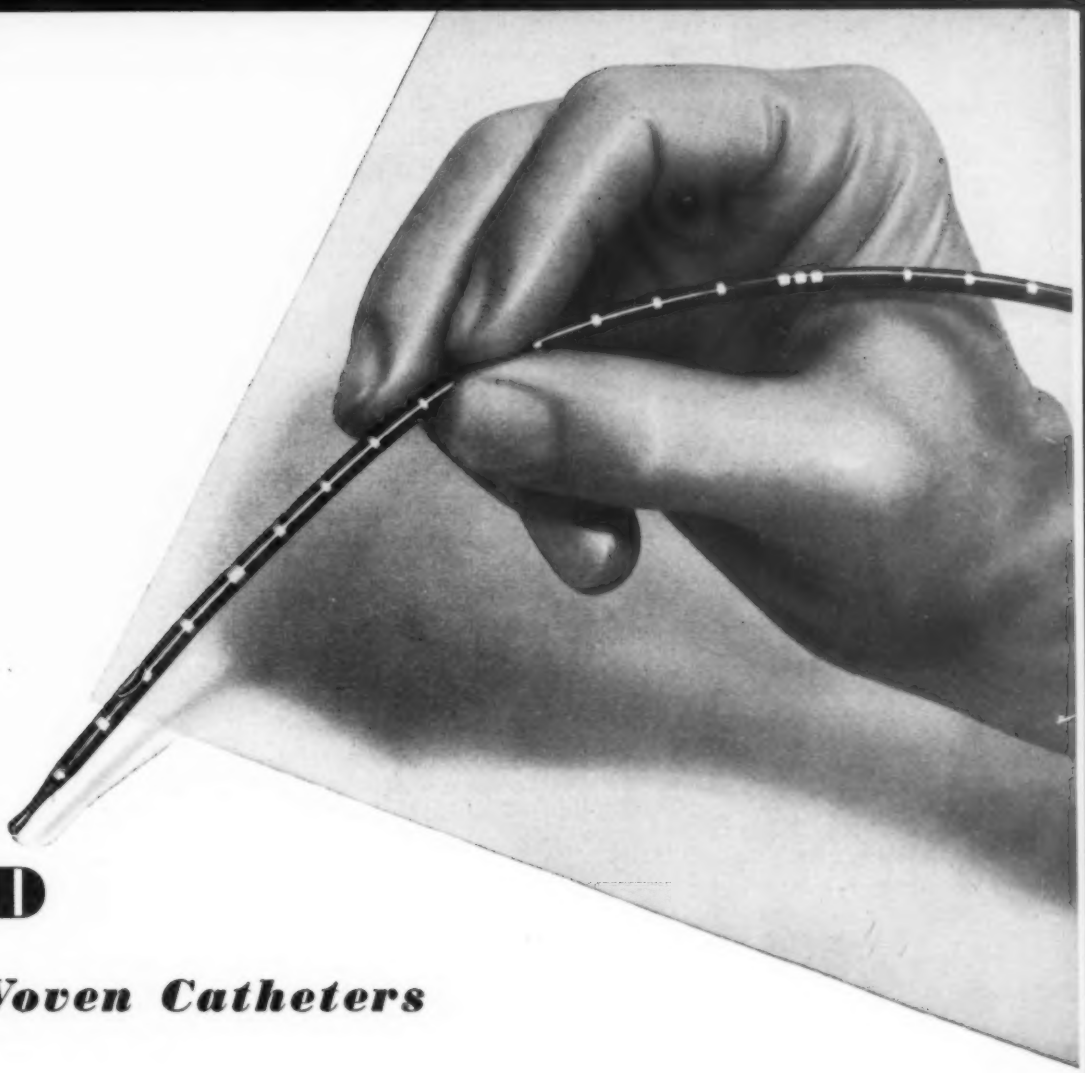
At a recent meeting of the executive committee of the Ontario Division, Canadian Red Cross, it was reported that the largest single item, in the budget of expenditures for 1936, was for Red Cross Outpost hospital service in isolated districts of northern Ontario, where hospital, medical, and nursing service cannot otherwise be obtained.

Monteith, Ont. — What is probably Canada's first special hospital for the study of silicosis will be established shortly by the Ontario Government at Monteith, 35 miles south of Timmins. It has been announced that the buildings known as the Northern Academy, first used as a returned soldiers' home and then as a school, will be used for this purpose. Silicosis is frequently encountered among miners working in the Pre-Cambrian Shield, and has been given considerable study by the Ontario Government.

Milan, Italy.—The International Hospital Association is now engaged in compiling a Yearbook, which however, will not be available until some time in 1938. The production of this work is being sponsored by the Milan Fair. It is proposed to include in the book a list of the hospitals throughout the world with certain selected data concerning each hospital. The preface will be printed in five languages, and the book will be divided into five sections: Africa, Asia, America, Australasia and Europe.

(From an article by Mrs. O. W. Rhynas, President of the Hospital Aids Association, concerning National Hospital Day.) . . . It was not long until war broke out in Crimea, and on October 19th, 1854, a letter was received by Florence Nightingale from the British Secretary of War, Sidney Herbert, asking her to consider going to Crimea under British military orders. After a decisive interview she sailed on October 25th, 1894, with a group of less than forty nurses. Sailing from Marseilles on the Victis, they arrived at Constantinople November 4th, and proceeded to Scutari General Hospital and Barrack Hospital to open the first chapter of what would be immortal history—written in deeds—by this Angel of Mercy, and heroine of the Crimea. Can you imagine the peace that came to the hearts of those brave and suffering men of the Crimea, when they found themselves tended by women (for it was the first time women were sent out to nurse the wounded British soldiers in battle)? Chloroform was almost unheard of and many suffering and dying men were everywhere.

It is said that before Florence Nightingale reached the wounded men, forty out of every hundred died, and afterward the death rate was reduced to two out of every hundred. Her name became a household word throughout the land, for the magnificent work she accomplished at the Crimea.



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A dozen post office radio stations around the shores of Britain maintain a constant listening watch, 24 hours a day, for requests for medical advice from ships within this range. One station at Potishead, in Somerset, can cope with appeals from much farther; it often receives calls from ships away out in the Atlantic, or in the Mediterranean.

The code word for this service is "Medico" and every station has a regular medical "contact"—a local hospital or a doctor in private practice—with alternative contacts in case the first is not immediately available.

If the ship has a radio telephone, the operator asks if the Master would like to talk directly to the doctor, in which case he is connected through the local telephone exchange like any caller ashore.

If the ship has only wireless telegraphy, the coast station operator notes down the morse message and telephones it to the doctor.

Where the case is grave or diagnosis at long distance especially difficult, the doctor will advise the Master to put into port as soon as possible. But in the majority of cases the doctor is able to give advice at once.—*Calcutta Medical Journal.*

International Cancer Congress

The Seventh International Cancer Congress will be held in London, England, from July 6-12, 1958, under the presidency of Sir Stanford Cade. Congress headquarters will be the Royal Festival Hall.

There will be two main sessions of the Congress: (a) experimental; (b) clinical and cancer control. Special emphasis will be placed on hormones and cancer, chemotherapy, carcinogenesis and cancer of the lung.

Registration forms and a preliminary program were available early in 1957 on application to the Secretary General, Seventh International Cancer Congress, 45 Lincoln's Inn Fields, London W.C. 2, England.

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Dietetic Treatment for Peptic Ulcer

The value of the dietetic treatment of peptic ulcer by means of "bland" foods has been assessed on: (1) 64 in-patients with gastric ulcers, and on (2) out-patients with gastric ulcers and 50 out-patients with duodenal ulcers.

The in-patients were divided into two equal groups; patients in one group were given the standard hospital ulcer diet, while in the other they were given an almost normal diet. The diets were strictly supervised throughout.

The results showed a slight but statistically insignificant advantage to the patients on the "almost normal" diet with regard to the proportion in whom the ulcers became completely healed (10/32, compared with 5/32) and the average amount healed for the whole group (70.3 per cent, compared with 65.1 per cent), and (if patients on milk drip are omitted) a significant advantage in the average amount of weight gained (5 lb. 8 oz. compared with 2 lb. 14 oz.). On the other hand, they showed an appreciable advantage over the patients on the standard ulcer diet with regard to the proportion who reported themselves completely free of pain throughout treatment (17/32, compared with 9/32).

The out-patients were either advised to continue for a year on the standard ulcer diet with which they had been previously treated, or were advised to revert to a wholly normal diet. At the end of a year, the proportion who had remained free of pain and in whom the ulcer was radiographically healed was practically the same in the groups (pain-free 22 per cent and 21 per cent, ulcer healed 45 per cent and 51 per cent).

Dieting with "bland" foods does not increase the rate of healing of peptic ulcers.—*The Lancet.*

In Spite of "Stress"

The life expectancy at birth among American wage earners and their families rose to a new high of 70.0 years in 1955—the 12th successive year to record a rise, it was reported by the Statistical Bulletin of the Metropolitan Life Insurance Company.

The bulletin revealed that the average length of life among its industrial policy-holders has increased five years since 1945, 10 years since 1935, and 24 years since 1909. In 1879-94, the earliest period for which data are available, the average was only 34 years.

Although non-white policyholders have been making greater gains than the white in recent years, their longevity still lags behind that of white policyholders. In 1955, the bulletin pointed out, the expectation of life at age five for Negro males was nearly two years less than that for white males; for females the disparity was as much as four and a half years.

However, white females have done better than males with the result that their life expectancy is greater than ever before. In 1955, the expectation of life at age five was 70.1 years for white females and 63.9 years for white males. The margin in favour of females decreases with advance in age, but it still amounts to 2.5 years at age 65, when the expectation of life is 15.1 years for white females and 12.5 years for white males.—*Scope Weekly.*

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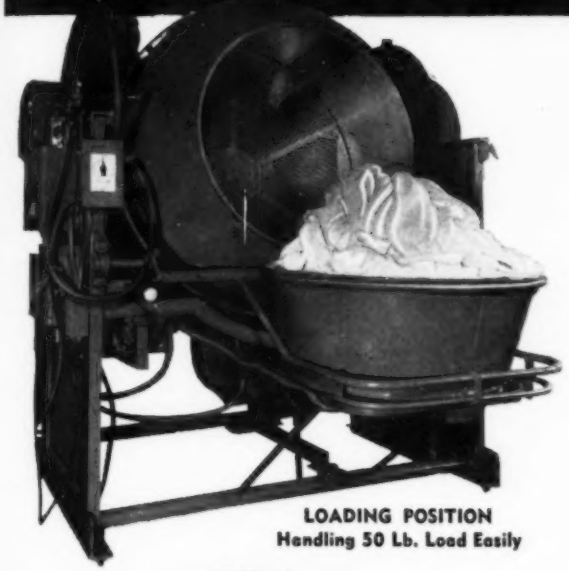

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Decrease in Industrial Accidents

"The trend in industrial accidents in Ontario is toward a decrease in the extent to which injured workmen are being permanently disabled, despite increases in manhours of exposure", E. E. Sparrow, chairman of the Workmen's Compensation Board reported recently.

Presenting the report to the legislative assembly, Labour Minister Charles Daley said, "Trends indicated show marked expansion in all phases of workmen's compensation administration."

In 1955, the W.C.B. paid out $34,335,714 in benefits to injured workmen. In 1956 the amount was increased to $39,419,001. An estimated $50,000,000 will be required in 1957.

Costs for medical aid to Ontario's workmen in 1956 increased to $10,421,686 over $9,445,739 in 1955.

In 1956, 65,000 employers representing an estimated 1,500,000 employees received coverage under the Act. With the extension of coverage to include retailers of goods, it is expected that in 1957, 120,000 employers with 1,750,000 employees will be protected. — *Workmen's Compensation Board, Ont.*

Here and There...

Manchester Training Scheme For Hospital Administrators

Now being developed at Manchester University, Manchester, England, is a three-year training program for hospital administrators. The course is designed mainly for young university graduates and other professionally qualified entrants.

The scheme gives students a one-year academic course and two years' practical training. The student-administrators will be registered as university students for the whole of their three year course and will read for a post-graduate diploma in Social Administration by full-time attendance in the academic year. Since theoretical discussions of administrative problems can be meaningless and sterile unless they take place against some previous practical experience, it was decided that the academic year would best be placed in the second year, following twelve-months in-service training. In the first year, an introductory course is provided at the university as well as two weeks of refresher course during the year.

The aim of the training is to provide students with some understanding of the organization and problems of each section of hospital work and its importance in the running of the service as a whole. Details of the training program will be designed individually so as to balance the needs of the student and his previous experience with the possibilities presented by the training centre to which he is attached.—*The Hospital.*

New Hope for Lepers

Nobody really knows how many lepers there are in the world. The nearest estimate, given by WHO in 1952, was "between two and seven million". A revised estimate last year gave the figure as "ten or even twelve million". Why the increase? Because leprosy is no more a disease of which its victims are so terrified that they hide their affliction. The figures have risen because lepers are more and more seeking medical aid.

In Nigeria for example, there were 52,000 patients in 1953. The 1956 figures are expected to reach 195,000.

The WHO Executive Board has stated that "considerable progress" can now be made against the disease, largely because of growing confidence in the new anti-leprosy drugs. Today WHO is helping in the leprosy control work of ten countries.—*"World Health", Jan.-Feb., 1957.*

Egyptian Nursing

An extensive program of social welfare has been undertaken by the Egyptian Government in the past few years, to combat the problems of over-population, illiteracy, disease and malnutrition.

Included in the program of village improvement, school expansion, desert land reclamation, irrigation projects and agricultural research, is a tremendous increase in health services, but the problem of staffing these services is acute. Medical education enjoys great prestige, and hundreds of young doctors are graduated each year; but nursing has not kept pace in development, and the present

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schools of nursing are inadequate both in quality and in quantity of their graduates.

Prejudice against this degrading occupation is not as intense as in 1827, when the first class of the Kasr El Aini School of Nursing had to be made up of ten young Sudanese and Abyssinian girls bought in the slave market, or the two later occasions when the board of the school requested that the police seize some suitable girls and bring them in as pupils. But prejudice still exists and the majority of nursing students are girls from the poorer families with not more than four years of primary education.

All reports have agreed on the principle that improvement in nursing must come from within the country itself, and that the first requirement is a nucleus of potential nursing leaders, girls of better social and educational background with adequate professional preparation.

A school was established as the Higher Institute of Nursing, a four-year degree program in the University of Alexandria, with provision for admission of students from other Arab Countries of the region. The curriculum was planned as comprehensive preparation for all fields of nursing.

According to the agreement, World Health Organization provided international nurse educators, teaching equipment and books, and fellowships both for regional students attending the institute and for qualified Egyptian nurses recommended for post-basic study abroad. The government of Egypt provided buildings, furnishings, local staff, administrative and maintenance, and transportation costs, and (when available) an Egyptian nurse counterpart for each member of the international staff. The first class of students was admitted in October, 1955.

Edith Green, a former director of nursing education at the Royal Jubilee Hospital, Victoria, British Columbia, was chosen as one of a Nursing Education Team in response to a request by the Government of Egypt to WHO for assistance in setting up a University School of Nursing for the Middle East Countries. The above information was given in her speech at the last annual meeting of the Registered Nurses' Association of British Columbia.

Converted Country Mansion Serves as Geriatric Hospital

A country mansion in the Royal Forest of Dean was purchased in August, 1953, by the Gloucester, Stroud and the Forest Hospital Management, England, for conversion into a geriatric hospital. The hospital, called Lydbrook, was opened late last year.

The house is located on rising ground overlooking the River Wye and is surrounded by woodland. The grounds are laid out with a small swimming pool, a rockery with a stream running through it, and shrubs and lawns stretching down to an Italian rose garden.

The necessary building adaptations were carried out by a local firm of contractors at a cost of £10,000. A large proportion of the beautiful oak panelling and wood block flooring in most of the rooms has been retained. Work on the site can only be undertaken with the permission of the Ministry of Works, since a part of Offa's Dyke, an ancient monument, dating from the 8th century, passes through the grounds of the hospital. — *Hospital and Health Management.*

Signs of Stress

Modern invention and labour saving machinery have relieved us of much physical drudgery, but there are signs that they have increased our nervous strain.

Aided by our gadgets, we live at high speed. "We are always", said Dr. J. B. Kirkpatrick, Director of the School of Physical Education at McGill University in an address a few years ago, "meeting deadlines, catching trains, grabbing a bite to eat. Our toes are tramped on and our tempers are frayed as we fight to get on board a street-car. We have lost some of the amenities of living in this mad scramble".

These exasperations of the day get us keyed up. The tension accompanies us home and keeps us awake, unless we have worked out for ourselves an effective way of releasing it.

One evil result of our hasty living is that we so often fail to solve our problems adequately. Much of the time we are tangled up in the woolly words with which we clothe our thoughts rather than with facts themselves. The result is a state of anxiety.

It is wholesome to have fear when it is an alarm bell, a warning of impending danger, but some of us go around in a perpetual aura of anxiety, as if we still thought the world to be flat and that we might fall over its edge. This pervasive anxiety prevents us from relaxing, keeps us tense. The protective patterns set in motion by our bodies are overworked.—*The Royal Bank of Canada Monthly Letter, January, 1957.*

Menace of Radiation

A ten-nation committee of scientists met in Copenhagen last summer under the auspices of the U.N. World Health Organization. Its report to the April, 1957, U.N. conference on atomic radiation was published in March.

Although the group reached no definite conclusions on the concealed dangers of genetic damage to the human race, there was unanimous agreement that "all man-made radiation must be regarded as harmful to man from the genetic point of view.

"There are strong grounds for believing that most genetic effects are very closely additive", the report said, "so that a small amount of radiation received by each of a large number of individuals can do an appreciable amount of damage to the population as a whole".

* Are you getting the best squeeze?

What in the world has this got to do with mopping floors? . . . it's quite logical, really, if you just stop to think how important a part the wringer plays in getting floors really clean. Actually, a wet, soggy mop does little towards achieving cleanliness at all, and unless you "get the right squeeze" your floors acquire a permanently lifeless appearance. "Geerpres" wringers are designed to solve this problem—and make mopping a faster, simpler and more satisfactory operation.

For more detailed information—see opposite page.

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Cancer and Modern Living

Is our modern way of living causing an increase in cancer?

In the first place, is there an increase in cancer deaths? According to the Canadian Cancer Society, the cancer death rate has risen slowly but steadily over the years. Last year it was 142 per 100,000 of population for men and 123 for women. But we must take into consideration that cancer is, to a large extent, a disease of the aged and as fewer people die of pneumonia, tuberculosis, and other diseases, more will live to die of heart disease and cancer.

At the same time more cancers are being cured than ever before. Cancers of the skin, mouth and other accessible sites are often successfully treated by radiation or surgery or both, especially if treatment is begun early.

On the other hand, the death rate from lung cancer has increased by 100 per cent over the past ten years. Last year more than 1,500 Canadian males and more than 300 females died from lung cancer.

There is no conclusive proof that this is due to cigarette smoking. Many investigators believe that the accumulation of carbon monoxide from car exhaust, the smoke from trains and factories, the oil fumes from countless chimneys, the tar from the roads and other air-polluting substances are all contributing to lung cancer.

It is known that all of these contain known cancer-causing chemicals called carcinogens. There are over 400 of these carcinogens and they turn up in such unlikely places as food dyes, preservatives, cosmetics, coal tar, cleaning and polishing agents, sanitary goods, and insecticides.

From this list one might get the idea that the best way to avoid cancer would be to quit eating, drinking, and breathing, but unfortunately we can't do that. There are, however, other things that can be done.

The control of air pollution is advocated by many scientists as the best means of controlling lung cancer. This task has been tackled successfully by some American communities and is being studied extensively in Canada. Also, much more attention is being paid to the chemicals that we add to food and elaborate "screening" tests are applied to most before they are used.

Most important of all are the precautions that each one of us can take against cancer. As stated earlier, many common types of cancer can be successfully treated if the growth is detected early. For this reason the Canadian Cancer Society advocates that each one of us should know the cancer danger signals, and, what is more important, have a medical check-up when one of them is suspected.

Cancer Society data can be obtained from any unit of the Canadian Cancer Society. Today many industries are taking advantage of the Society's industrial education program. They are setting up in-plant committees of the Society that take over the responsibility for making available pamphlets, posters, films and speakers. They even arrange for nurses to visit the plant and give personal interviews to those requiring them.

Of course, the only complete answer to the cancer problem lies in research. When scientists discover the cause of cancer they

(concluded on page 110)

Cancer

(concluded from page 108)

will likely be able to develop better over-all cures and even means of prevention.

Most of the money raised during the Canadian Cancer Society's annual campaign for funds (held in April) is being used to support an expanding research program in this country.—*Release from the Canadian Cancer Society.*

How to have Luck with Plants

A green thumb isn't needed to provide successful care for foliage plants, says the American Association of Nurserymen. Green plants can contribute much to a friendly atmosphere and, with the proper care, will add an attractive note to an institution's interior for a long period of time.

The normal temperature of a room, between 65 and 80 degrees, is the temperature range of foliage plants.

Although the plants require plenty of light, they require little or no direct sun. Light from southeast or east windows is ideal, or sunlight filtered through sheer curtains. Fluorescent or electric light can also be used.

Since foliage plants do best with warm humid air and well drained soil, sprinkle them freely with water. Then use a bulb-type sprinkler, washing the leaves thoroughly. Moisten the soil with water—never keep the soil of any plant soaking wet. It sours the soil. Use lukewarm water.

Use artificial plant foods sparingly, preferably those dissolved in water, says the association.

To trim the plant always cut off just above a leaf point. To shine the leaves use ordinary milk on a soft cloth. Do not use oils that clog the pores.

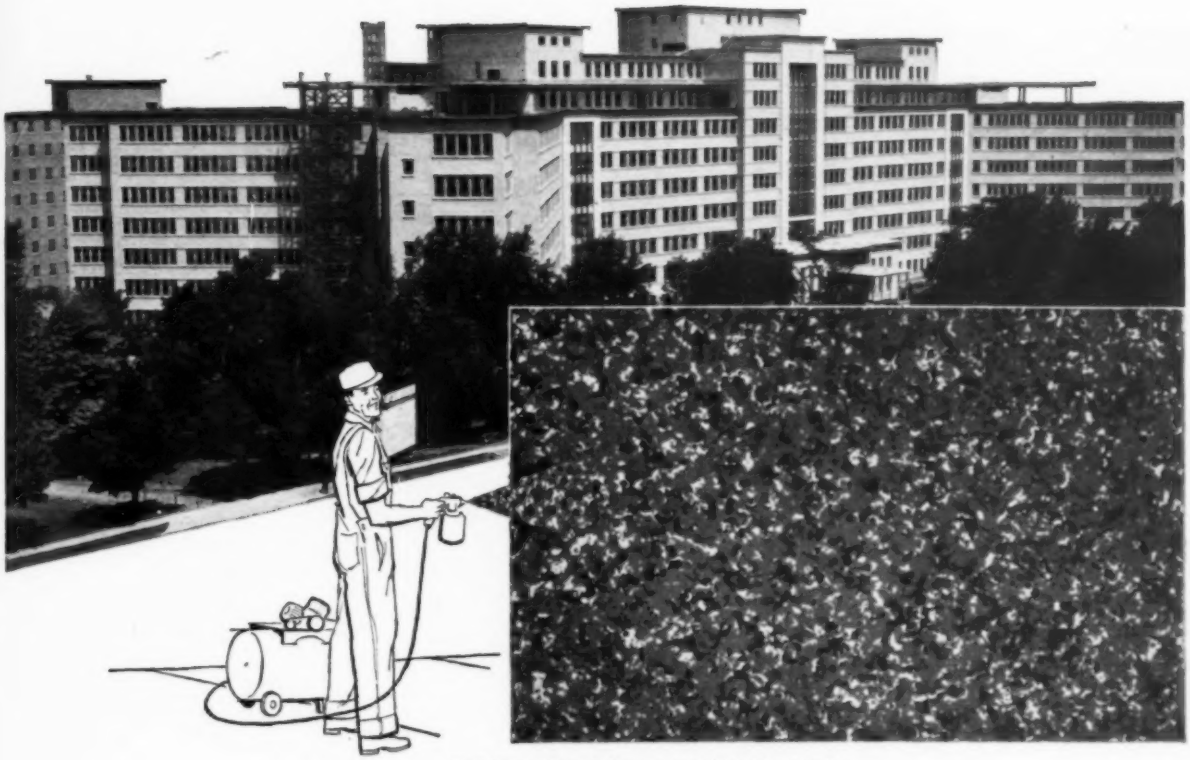
When transplanting use rich, porous soil, leafmold, garden loam and sand in equal proportions. Light soil is preferable. Do not transplant, however, until the plant is ready for it. Some roots of tropical plants may show on the soil surface, but this doesn't necessarily mean they need replanting.

Having "luck" with plants, even with the hardier ones like philodendrons and dieffenbachias, may also depend on securing advice from a nurseryman.—*Institutions.*

Indigestion: The failure to adjust a square meal to a round stomach.

Durable, washable **ROXATONE*** *the colour-flecked plastic finish*

was used in the new Ste. Justine Hospital



Architects: Joseph Sawyer and Henri S. Labelle
General Contractor: Damien Boileau Ltée.

ROXATONE decorator finish was used extensively in the Ste. Justine Hospital for these major reasons:

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Le Secretariat de l'Action Catholique
Hotel London, London, Ont.
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BOOK REVIEWS

CENTRAL SUPPLY YEARBOOK. Published by *Hospital Topics*, 30 West Washington Street, Chicago 2, Illinois. Ill. Price $1.50. Pp. 107.

This book contains a series of select articles on central supply planning and operation in hospitals. They were chosen by the editors from the literature which has appeared in the central supply section of *Hospital Topics* since 1952. This publication offers not only solutions to central supply problems, but also ideas for improving the efficiency of that supply and thereby improving patient care in the hospital.

The articles range in subject matter from syringe and needle processing to planning and standardization in the central supply department. Moreover, the book is amply and clearly illustrated.

In evaluating the importance of this particular subject, the author of the first article points out that as one of America's largest industries, hospitals must stand committed to efficient and sound business operation. "A well-planned central supply unit increases productivity. Through elimination of duplication, it is possible to operate with fewer units of each instrument or other needed items, yet because of this reduction, to provide for a more widespread selection at no increase in cost." It is concluded that a well-organized supply unit lends itself to optimum utilization of personnel and that administrators may well view a centralized supply service as a basic factor in a smooth-running hospital.

The rapid growth and acceptance of central supply as an important department in efficient hospital operation makes this book a valuable addition to hospital literature.

TRENDS—A Ready Reference of Hospital Facts and Figures. By Louis Block, Dr. P.H., Chief, Research Grants Branch, Division of Hospital and Medical Facilities, United States Public Health Service, Department of Health, Education, and Welfare. Published by Hospital Topics, Chicago. Illustrated. Price $5.00. Pp. 222.

This volume is a compilation of statistical data pertaining to hospitals in the United States over recent years. While most of the material contained in it is necessarily

historical, it is true, as the author points out, that "only by observing the trends . . . indicated by such data and by studying and analyzing them are we able to estimate with any degree of intelligence what may be expected in the future and what safeguards are to be instituted to guarantee that the errors of the past will not be repeated and, at the same time, to effect greater economy and efficiency in hospital operation." Dr. Block examines and analyzes hospital trends in the matters of size, occupancy, admissions, personnel, income, expenses, and other categories. He studies the average hospital under the headings, short-term general, long-term general, mental, tuberculosis, and federal. Among the chapters in the section on "Management and Planning Mechanisms," the one dealing with "Adequate Financial Support for Hospital Maintenance and Operation" is of some special interest.

While no bibliography as such is included, reference notes throughout the book would indicate that the author has used data provided in the *Administrators Guide Issue*, published annually by *Hospitals*, Journal of the American Hospital Association; annual hospital numbers published by the *Journal of the American Medical Association;* data made available by the United Hospital Fund of New York; and by the National Office of Vital Statistics, United States Public Health Service, Washington.

National Hospital Day Contest Award

Instructor of nurses at Renfrew's Victoria Hospital, Moira K. Smee, won first prize in the Ontario Hospital Association's National Hospital Day Contest in which 222 entries were judged. Requested to complete the sentence "I chose a hospital career because . . ." in twenty-five words or less, she stated, " . . . I decided that it was the best profession in which to work with my head, my hands and my heart." Shirley Turner, a student nurse at the Toronto East General Hospital, placed second; while Helen M. Tinline, laboratory technologist at the Hospital for Sick Children, placed third. The contest was designed to tie in with current National Hospital Day promotion which this year is aimed at secondary school students in an effort to stimulate interest in hospital careers.—*Hospital Highlights.*

"Uneasy is the tooth that wears a crown."

For Trustees Only
(continued from page 55)

pertinent statistics; and this is particularly true as regards staff requirements. Should we need any further proof of budgets as management tools, we need only look at the experience of the hospitals in those areas where some form of compulsory hospital insurance has been instituted. In both Saskatchewan and British Columbia payments to hospitals are predicated upon budget predictions; and, in Alberta, almost all-inclusive services must be provided at a fixed and pre-determined figure.

Statistical supplements to our financial statements also provide pertinent information which in many cases can be related in financial terms. Activities of our special departments must be watched and sight ratios developed which will enable us to determine the quantity of service being demanded for our patients. We should remember that ultimate cost of hospital care to the patient is not only determined by established rates but, perhaps more importantly, by volume of care or services provided. It is granted that these considerations are and should be basically the responsibility of the members of the medical staff but, if we recognize that the administrator is the one person who is in the best position to evaluate all activities in the hospital as reflected in its financial operations, then he or she must be the person who provides the impetus for review and examination of existing procedures in others.

New Buildings

One of the financial problems frequently faced today by hospitals and their administrators is in the initial operation of new or extended buildings. Population increases and changing hospital habits of our people have brought demands for more hospital beds and facilities from almost every part of the country. Usually no special provision is made for necessary working capital when a hospital is first opened or even when a fairly large extension is completed. Obviously there will be difficult financial times in these initial stages and we have seen several cases where such circumstances have provided rocky going for the administrator. I wonder if these administrators provided their governing boards with a carefully prepared budget forecast and made it crystal-clear that there would be a difficult period to face while staffs were being organized and occupancy was low? A budget gives an opportunity to consider difficulties before they arise. Obviously it will not provide funds nor obviate deficit operations at some times and under certain conditions. It should, however, indicate that careful consideration has been given to all factors involved and that precautions are being taken to keep necessary deficits to a minimum.

Internal Audit

For administrators of medium and larger-sized hospitals, I would especially commend consideration of a formal part in your organization for an internal control or internal audit function. Industry generally has found this management tool of growing value and, as the writer views the many problems of organization and management which enter into the daily life of the hospital administrator, it would seem much of value could result by adapting this management device to the hospital field. Adequate internal control will help your hos-

(concluded on page 120)

Mayors Study Civil Defence

Approximately 100 mayors from the larger metropolitan and urban municipalities in Canada conferred at the Civil Defence College, Arnprior, Ontario, from February 27th to March 2nd. The meeting was held at the request of the Canadian Federation of Mayors and Municipalities and was the result of a resolution passed at the 1956 Hamilton conference of the Federation.

The purpose of the conference was to acquaint those attending with details of approved Civil Defence plans. The agenda included the Federal Civil Defence policy, Civil Defence organization and planning, the financial aid program, the rôle of the Armed Services and Civil Defence and the Air Defence of Canada.

One of the highlights of the conference was an airlift from Ottawa's Uplands Airport to Air Defence Command at St. Hubert's, Quebec, on March the 1st. The mayors were taken from Ottawa via R.C.A.F. North Stars.

The Honourable Paul Martin, Minister of National Health and Welfare and Federal Cabinet Minister responsible for Civil Defence stated:

"This is the first time in the history of Civil Defence that the federal organization has had an opportunity to speak and confer with the mayors of Canada at the Canadian Civil Defence College. We are most pleased with the interest that the Canadian Federation of Mayors and Municipalities has shown in the national, provincial and local Civil Defence program in Canada. We hope that this conference will further the municipal interest in Civil Defence and through it there will materialize a better realization and understanding of the necessity for the Civil Defence program in this country".

Besides Mr. Martin and speakers from Federal Civil Defence Headquarters, the Hon. R. O. Campney, Minister of National Defence, the Hon. Lester B. Pearson, Minister for External Affairs, General C. Foulkes, Chairman, Chiefs of Staff, Department of National Defence, and A-V-M L. E. Wray, General Officer Commanding, Air Defence Command, addressed the conference.—*Department of National Health and Welfare.*

For Trustees Only
(concluded from page 114)

pital by giving assurance that accounting and statistical reports, which management must rely on to control operation of the hospital, are reliable. It will aid in safeguarding assets, in prevention and detection of errors, waste and fraud, and in protecting employees against their own human weaknesses. Detailed examination of the possibilities of this tool will, I am sure, prove interesting and exciting. Any living organization must be under constant surveillance to determine that prescribed policies are being carried out, that changes in operating conditions have not made the procedure cumbersome, obsolete or inadequate, and that where breakdowns in the system appear, effective corrective measures are taken promptly. No matter how good an original system is, constant review is necessary, or it will deteriorate. I question whether we, as administrators, have sufficient time to maintain the type of continual review which might provide us with better means of meeting financial problems in hospital administration which will be always with us.

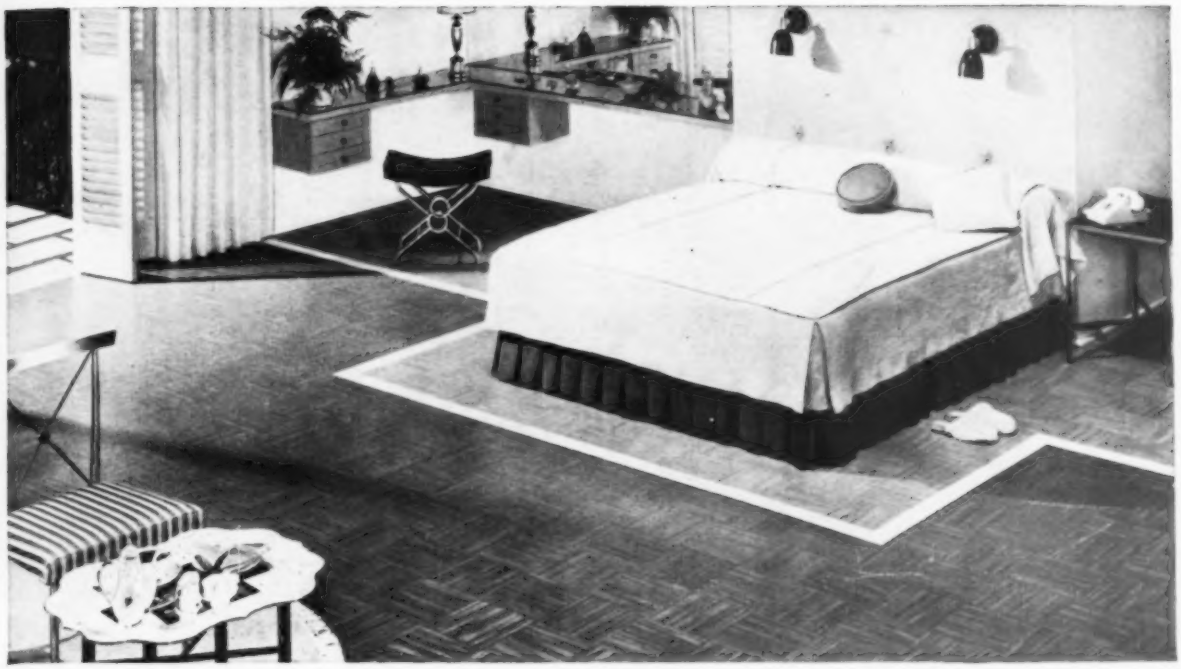
Financial Story

I have spoken about the need at the administrative level for adequate reports containing sufficient detail for careful evaluation of operations of the whole hospital. The conscientious administrator will give careful thought as to the best manner in which necessary financial data can be placed before the board of trustees. Usually they are busy men or women in their own right and can be quickly disinterested by too much detail. Obviously they must have pertinent facts in as concise and interesting a form as possible. I question the need of presenting each month page after page of detailed accounts payable for the month. I sincerely wonder how many trustees pay any attention to an abstract listing of expense breakdowns extracted in statement form from the general ledger. Do we not often becloud major issues and concerns of our busy trustees by not continually reviewing our financial reporting in order that main considerations only, on which policy must be set, are brought forcibly to their attention. And further to all of these considerations—are we showing real ingenuity in telling the most important story to our community?

I realize it is very easy to ask questions without supplying specific answers but I have purposely raised certain points in the hope that we will think about them seriously. Learning to think is important. It is only through our ability to think in logical fashion that we are able to solve successfully the many problems which we, as administrators, face in our everyday life. Then, too, in this day of strains and pressures, we must be able to think for ourselves. Only thus can we be leaders, as well as followers. Luther Burbank once said, "The greatest happiness in the world is to make others happy; and the next greatest thing is to make them think".

Provides Food Conveyor

The "meals on wheels"—a food conveyor which the Women's Auxiliary to Our Lady of the Rosary Hospital, Castor, Alberta, have purchased—arrived after many months of waiting. The conveyor can be wheeled out of the kitchen and plugged in on the first and second floor, ensuring hot delivery of food.



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News Released by Hospital Supply Houses

By C.A.E.

Fred N. Dundas Named GCMI Trustee

Fred N. Dundas, executive vice-president of Dominion Glass Company, Limited, headquarters of which are in Montreal, was elected to the board of trustees of the Glass Container Manufacturers Institute, Inc., at a recent meeting of the trustees, according to an announcement made by Victor L. Hall, GCMI's general manager.

Schering Releases Arthritis Film

A new 16 mm. colour motion picture on the uses of steroids in the treatment of rheumatoid arthritis has been released for showing to professional groups by the research division of Schering Corporation.

The film reviews the chemistry, physiology and clinical application of the new "Meti" steroid hormones in rheumatoid arthritis and other collagen diseases. It presents the most commonly accepted theories of adrenal corticosteroid therapy and reflects the current knowledge of the subject.

The 25 minute film, which is the fourth of Schering's series on hormone therapy and the endocrines, was produced by the company's Clinical Research Division and Biochemical Research Department.

The film is available to medical and allied professional groups on loan without charge. "'Meti' Steroids in Rheumatoid Arthritis" and other Schering films may be obtained by writing to the Professional Service Department, Schering Corporation Limited, Montreal, P.Q.

Dr. J. H. Keil Heads Wilson Research Laboratory

James H. Wilson, President of James H. Wilson Ltd., announces the appointment of J. H. Keil, Ph.D., as head of their research and quality control laboratory.

Dr. Keil is a graduate of the University of Dresden and was, for a time afterward, a staff professor there. He was also a member of the German Research Association. He conducted research work for the German Aluminum Industries.

After the war, Dr. Keil conducted intensive research in the field of synthetic materials.

Colgate-Palmolive Appointment

B. J. Cooper has joined the industrial sales staff of Colgate-Palmolive Ltd. and will be servicing clients in the downtown Toronto area. Mr. Cooper attended Brampton High School and the University of Toronto.

Bulletin on Refrigerating Machine

An 8-page, 8½ in. x 11 in., well-illustrated, two-colour catalog (Bulletin 1426) describing the advanced design Tonrac single-stage hermetic centrifugal refrigerating machine is now available from American Standard Products (Canada) Ltd., Canadian Sirocco Products, Windsor, Ontario.

The new bulletin describes in detail the features of Tonrac that make it unique among refrigerating machines. A cut-away photograph illustrates the various construction details, including condenser, single-stage compressor, marine-type water boxes, evaporator, tube bundle, float valve, lubrication system, motor and purge system.

Research and test facilities used at American-Standard in developing and proving the Tonrac machine are illustrated and described. Also included are photographs of a typical installation. Related refrigerating and air conditioning equipment produced by American Standard are also listed and illustrated.

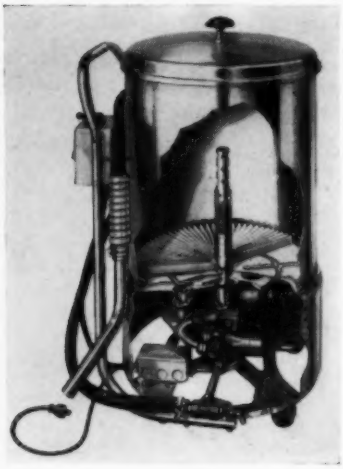
(continued on page 124)

Across the Desk

(continued from page 122)

The "Fry-Saver" Does Not Require Filtering Aids

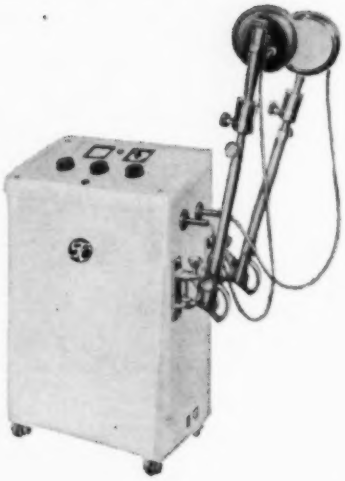
The messy task of filtering cooking fat has been simplified and made almost automatic by S. Blickman, Inc. of Weehawken, N.Y., manufacturers of food service equipment, who are introducing a new fat filtering machine called Fry-Saver.



Fry-Saver is the first cooking fat filtering machine to operate without any filtering aids. The cooking fat filters through a microscopically fine Porosite filter cartridge which removes all sludge and other impurities in the fat. This specially designed filter cartridge provides fifteen times the filtering area of a disk of equal circumference. The cartridge is easily replaceable when required, and it has a special handle, so that the task of removing the filter is no longer an unpleasant job.

This new method of fat filtering is practically automatic, operating like a high-powered vacuum cleaner. With the Fry-Saver an employee can quickly drain the unfiltered cooking fat out of the fryer through the Fry-Saver intake hose, a new feature which eliminates the dangerous and unpleasant job of draining this fat through the filter cock underneath the fryer. The fat is then purified through the filter, and if any residue remains in the fat chamber of the fryer, the Fry-Saver can clean it out with a filtered hot cooking fat flush which is pumped back into the fryer through the same hose.

For further details contact: Wrought Iron Range Company of Canada, Limited, Toronto.



Diathermy Machine for High Frequency Therapy

A new type of diathermy machine for high frequency therapy is being manufactured in Canada. An electronic tuner automatically maintains the dosage at unchanging intensity when the patient moves, awake or asleep, during treatment. Thus the attending physician is enabled to set the prescribed wattage and sustain it for the treatment duration, obviating the attention of attending personnel.

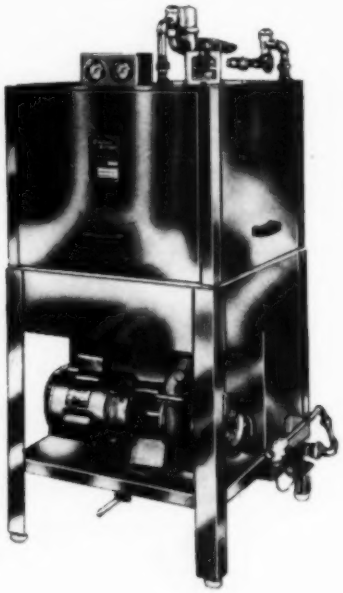
Applications include hyperthermal therapy and unipolar treatment, the latter heretofore requiring special microwave equipment. The manufacturers are Standard Telephone & Cables Mfg. Co. (Canada) Ltd., 9600 St. Lawrence Blvd., Montreal. Literature available on request.

Moffats Limited to Handle Autosan Dishwashing Equipment

The Vulcan-Hart Manufacturing Company Inc. have announced the appointment of Moffats Limited as exclusive Canadian distributors for Autosan Dishwashing Machines, manufactured by Vulcan-Hart in the U.S.A. for use in hospitals, restaurants, hotels and institutions. Vulcan commercial cooking equipment has been handled in Canada exclusively by Moffats for the past 7 years.

According to the manufacturers, "Autosan" equipment represents the ultimate in fully automatic dishwashing and drying equipment. In the four continuous conveyor models, "auto-racking" and "cloudburst" power washing combine to promote special safety and sanitary features. The equipment is 3-tank, all-welded stainless steel. It comes complete with motors, valves, thermostats, thermometers, waste line connections and sanitizing steam booster. Continuous conveyor models will handle all types of tableware and trays. Capacity is from 10,000 to 15,000 dishes an hour.

In other "Autosan" models capacity ranges from 800 to 9,000 dishes an hour.



Stain-Free Dishwashing With New Divoklor

A new chlorinated machine dishwashing compound which simultaneously cleans and prevents staining of dishware has been developed by The Diversey Corporation. Called Divoklor, the new compound penetrates scratched surfaces and removes deeply imbedded stains.

Equally important to the food service manager is Divoklor's fast-acting removal of dried-on food, lipstick, grease and oils. Even already-stained dishware regains most of its original lustre with the new compound, reports Diversey.

For further information concerning Divoklor, write to Institutions Department, The Diversey Corporation (Canada) Limited, Port Credit, Ontario.

G. H. Wood & Company Appointments

Geoffrey H. Wood, President and General Manager, G. H. Wood & Company Limited, announces the

appointment of J. Sheldon Foley as Central Ontario Division Manager with headquarters in Hamilton. Mr. Foley will be in charge of the Company's operations in Niagara Falls, St. Catharines, Hamilton, Brantford, Kitchener, Owen Sound and surrounding territory.

Arthur Holland is Kitchener Branch Manager, Fred Marchant is Owen Sound Branch Manager, and Dave Jack is Branch Manager for St. Catharines and Niagara Falls.

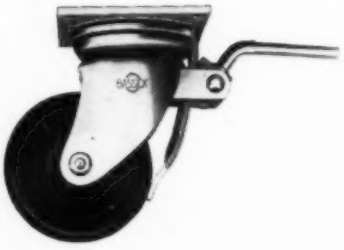
J. Guy Bell has been appointed Western Ontario Division Manager with headquarters in London. Mr. Bell has been Branch Manager of the London Office for the past fifteen years, and will now be in charge of the Company's operations throughout the Windsor, Chatham, London and Sarnia Areas.

Art Bezaire is Branch Manager for Windsor and Lionel McDonald is Branch Manager for Chatham.

New Bassick Combination Wheel Brake and Swivel Lock Caster

Just introduced by Stewart-Warner Corporation, Belleville, is a new Combination Wheel Brake and Swivel Lock now available on Bassick Swivel Plate Casters.

This new wheel brake and swivel lock caster meets a need that the industry has felt for some time.



With it, many types of castered portable equipment can now be held securely in a fixed position. For some applications on work platforms, stands, portable racks, and trucks, it makes the use of separate position locks unnecessary.

The top quality, double ball race, formed steel casters are designed to take the abuse of rough service. The large diameter ball race provides quiet, fast and easy swivelling. All bearing surfaces are curved to give maximum ball contact and are fully case hardened for extra wear resistance and long life. Bassick Wheel Brake and Swivel Lock Casters are available in 5 in., 6 in. and 8 in. sizes.

Index of Advertisers

MAY, 1957

Authorized as Second Class Mail, Post Office Department, Ottawa. The Canadian Hospital is published by The Canadian Hospital Association, 57 Bloor Street West, Toronto 5.